No 5-573.149
15-7-169

GIVEN BY
U. S. Supt of Doc'ts.

U. S. DEPARTMENT OF LABOR
JAMES J. DAVIS, Secretary
CHILDREN'S BUREAU
GRACE ABBOTT, Chief

A STUDY OF MATERNITY HOMES IN MINNESOTA AND PENNSYLVANIA

Bureau Publication No. 167

WASHINGTON
GOVERNMENT PRINTING OFFICE
1926

SINGLE COPIES
OF THIS PUBLICATION MAY BE OBTAINED FREE UPON
APPLICATION TO THE CHILDREN'S BUREAU

ADDITIONAL COPIES MAY BE PROCURED FROM
THE SUPERINTENDENT OF DOCUMENTS
GOVERNMENT PRINTING OFFICE
WASHINGTON, D. C.
AT
15 CENTS PER COPY

U. S. SUPERINTENDENT OF DOCUMENTS
JAN 13 1927

CONTENTS

LETTER OF TRANSMITTAL

United States Department of Labor,
Children's Bureau,
Washington, March 10, 1926.

Sir: There is transmitted herewith a report on a study of maternity homes in Minnesota and Pennsylvania. This investigation was made under the direction of the author of the report, Dr. Ethel M. Watters, then associate director of the maternity and infant-hygiene division of the Children's Bureau. The medical data were collected by Dr. June M. Hull and the social data by Miss A. Madorah Donahue, both of the staff of the division. The work was made possible by the cooperation of the State board of health and the State board of control, of Minnesota, and of the State department of health and the State department of welfare, of Pennsylvania. The bureau is indebted to the directors of these agencies and their staffs for much assistance.

Respectfully submitted.

Grace Abbott, *Chief.*

Hon. James J. Davis,
Secretary of Labor.

A STUDY OF MATERNITY HOMES IN MINNESOTA AND PENNSYLVANIA

INTRODUCTORY SUMMARY

PURPOSE AND SIGNIFICANCE OF STUDY

Maternity homes have not been given much attention in the United States. It has not been the usual procedure here, as it is in England, to license them or to give them the status of small hospitals. The term "maternity home" has not been defined in most States, either in the statutes relating to the protection of maternity and infancy or by common medical or social usage. The chief purposes for which many of these institutions were founded were the moral reclamation of "unfortunate women"—prostitutes and those addicted to drugs or alcohol—and the provision of shelter for indigent women. The homes provided religious instruction as well as obstetrical service and care before and after confinement, and some of them also placed babies soon after birth. They have been known most commonly as rescue homes, mission homes, asylums, or shelters. In their work the permanent health and physical well-being of mothers and babies were not generally considered factors of foremost importance.

With regard to policy the homes could be classified in three groups. The special policy of one group was to protect the mothers from publicity; of another, to bring about their moral reclamation; and of the third, to bring about their reclamation and also to save the lives of their babies. This difference in the homes' policies is still noticeable.

In the past practical training or help in economic and social adjustment after leaving the home was rarely given the mother, and little or no effort was made to establish paternal responsibility for her baby. Neither through their own efforts nor through cooperative relations with other agencies did the homes attempt constructive social treatment. Within recent years, however, there has been a gradual tendency for the homes to limit their intake chiefly to unmarried mothers and to develop their medical and social service to include prenatal, postnatal, and infant care and the preparation of the mother for economic, moral, and social adjustment in the community.

A study of the medical and nursing problems involved in maternity-home work and of the results of the various methods of social care and legal protection developed in relation to it is therefore of interest to physicians and nurses and to social workers in various fields. The interdependence of medical, nursing, and social work in any maternity-home undertaking has given to this study a twofold purpose: (1)

Analysis of work of the homes as agencies in establishing standards of prenatal, confinement, postnatal, and infant care; (2) evaluation of the social practices of the homes. In the course of the study the value of legislation providing for State regulation and supervision of maternity homes has also been considered.

For the purpose of this study a maternity home is defined as any institution which cares for women during pregnancy, provides for their confinement care (whether within the home or at a cooperating hospital), and after confinement cares for them and their infants for a varying period of time. This somewhat arbitrary definition was adopted in order to limit the scope of the study, which was not intended to include the large maternity hospitals. Many of the homes included in the study gave confinement care within the home, but a number sent their patients to local hospitals for this care. Separate records were kept of the confinement care when it was given outside the home.

Pennsylvania and Minnesota were chosen for this study because of the cordial cooperation extended to the bureau by the Pennsylvania State Department of Welfare and the Minnesota State Board of Control, and because of the marked contrast in the legal status of maternity homes in the two States. At the time of the study Pennsylvania had no law requiring all such homes to be licensed, but the State department of welfare was authorized to supervise them as child-caring institutions. In Minnesota since 1919 legal authority for licensing and inspecting maternity homes has been vested in the State board of control.

Thirty-five homes were included in the study—11 in Minnesota and 24 in Pennsylvania.

In Minnesota the original list of 22 homes furnished by the State department of public welfare contained the names and addresses of individual laywomen in different parts of the State who were opening their homes to the patients of local doctors but were making no attempt to give prenatal or postnatal care. Although 11 such homes were visited they were not included in the study because the care offered was too restricted for them to be classed as maternity homes as defined for the purpose of this study.

In Pennsylvania a list of institutions was furnished by the State department of welfare. As there was no centralized registration of maternity homes at the time of the study except those which were State aided this list was not complete, and through efforts of the members of the staff of both the child-health division and the public health nursing division of the State department of health it was considerably increased. A preliminary study of these places was made to eliminate those which did not conform to the definition of maternity homes already given. Twenty-one were found to be maternity homes; 74, maternity hospitals; 5, hospitals which cooperated by giving obstetrical care to the patients of certain maternity homes; 6, institutions which did not care for expectant mothers. Ten were not found. Fourteen more places were found through the assistance of local workers in different parts of the State; of these 3 were maternity homes, 1 was a cooperating hospital, 6 were maternity hospitals, and 4 were temporary shelters. The final number of maternity homes studied in Pennsylvania was 24.

Two schedules, one for medical data, the other for social, were used for each institution studied. A physician and a social worker visited each institution and interviewed superintendents, matrons, attending and consulting physicians, nurses, and social workers. In most of the homes the individual records of the patients for the period of one year (the calendar year 1922, whenever possible) were studied in order to ascertain the methods of care used, the plans made for mothers and babies, the status of patients when discharged, and the amount and kind of supervision after discharge. In many of the homes the bureau agent came into some contact with the patients and thus was able to form an opinion of the types of persons admitted and of their reactions to the home. In order to evaluate more accurately the social methods employed by the homes conferences were held with representatives of local social agencies, public and private, and with members of the governing boards of the homes and other individuals actively interested in them.

Although widely differing views may be held as to the details of policy and management which should prevail in maternity-home work, certain minimum standards of prenatal, confinement, and postnatal care to which every mother and baby are entitled, and of special care to which the child born out of wedlock has a right, have been worked out through conferences called by the Children's Bureau and are reprinted in the appendix to this report (see p. 87). Two of the homes studied, one in Minnesota (see p. 33) and one in Pennsylvania (see p. 66), gave care which very nearly measured up to or approximated these standards.

CONDITIONS FOUND IN TWO STATES

The maternity homes studied in the two States had similar origins and early histories; they were established chiefly from religious motives, and they admitted not only maternity cases but also almost any type of woman or girl needing shelter, care, or moral rehabilitation. Certain conditions and policies in the homes also were similar in the two States at the time of the study, but an analysis of the various administrative policies of the homes and of their medical and social practices and results shows considerable variation in the extent to which the homes measured up to the accepted standards of care for mothers and babies.

MEDICAL AND PHYSICAL DATA

Prenatal care.

Medical examinations and supervision.—In Minnesota every home except one (and when this one was visited new policies were in process of adoption) gave the patients at the time of admission complete and thorough obstetrical and physical examinations (including Wassermann tests and vaginal smears), which are recognized as the first essentials in the care of expectant mothers. In Pennsylvania, although all but one home gave a physical examination which included pelvic measurements, urinalysis, and blood pressure, less than half gave the Wassermann blood test as part of the routine examinations, and only one-fourth gave the Wassermann test of placental blood; in more than one-fourth the examination was so superficial that venereal infections might easily have escaped detection.

Seven of the Minnesota homes used the State university laboratory for their work. The others either had their own laboratory or used that of a cooperating hospital or clinic. In Pennsylvania two-thirds of the homes used the laboratory of a State, a borough, or a city health department, and eight had their own laboratory or the use of that of a private physician.

Medical supervision of patients during pregnancy, with attention to individual needs, was "excellent" or "good" [1] in the large majority of Minnesota homes, those closely in touch with the medical school of the University of Minnesota having very satisfactory practices. Excellent records on medical care were practically universal in the Minnesota homes, but in the Pennsylvania homes records were not so well kept, a few homes keeping none. In both States, however, the prenatal examinations were apparently given at regular intervals—weekly, semimonthly, or monthly; and individual instruction was given the mothers in regard to their physical condition. In 14 of the Pennsylvania homes and in 5 of those in Minnesota the prenatal examinations were given in the home; in the others the patients were taken to clinics, although a few homes arranged for examinations in the home when pregnancy was far advanced.

There is much to be said both for and against all the medical care being provided in the home. Some persons maintain that it is more costly for the community to supply proper equipment and service for physical and obstetrical examinations and also for confinement care; others, that it is much better to give all the care in the home, whatever the cost. It is claimed that the unmarried mother especially is less likely to be a further expense to society if her care is given entirely under the influence of the home, particularly the bedside care. According to Dr. Janet Campbell, the pregnant woman should live in a "physiological rather than a pathological atmosphere." [2] Just what emergencies can be met in the ordinary delivery room of a maternity home may be a matter of difference of opinion, but the prenatal care should be such as to preclude these emergencies as far as possible.

In the absence of complete facilities for medical care in the home the home should arrange for obstetrical examinations at a clinic and for the services of a laboratory and should employ a trained nurse. If the clinic keeps complete records which are available to the obstetrician the pregnancy can be properly supervised and safeguarded. A trained maternity nurse from the clinic or on the staff of the home can make the proper connecting link between the patients and these cooperating agencies.

For adequate care of mothers and babies it is very important that the superintendent of a maternity home should be a trained and intelligent person who will carry out the directions of the physician. In some of the homes visited the medical service was found to be highly standardized; but the maternity-home staff failed to cooperate with the physicians, so that the results of the home's work were not

[1] The terms by which the homes were rated were: Excellent, good, fair, and poor.

[2] Health, Ministry of [Great Britain]: Maternity Homes, by Dr. Janet M. Campbell, Senior Medical Officer, Maternity and Child Welfare. London, 1921.

wholly satisfactory. Although the superintendents in nearly all the homes in both States were kindly and were interested in their charges, those in Minnesota had had more training and education to fit them for their work than those in Pennsylvania, more than half of whom as compared with 3 in the 11 homes studied in Minnesota had only an elementary education. Five Minnesota and eight Pennsylvania superintendents were college graduates or graduate nurses (of these one in each State was a physician). In homes which undertook several types of work the physical care of expectant and nursing mothers was found to be less satisfactory than in homes which undertook only one. The homes in Minnesota did not give so many kinds of service as did those in Pennsylvania. Sixteen of the Pennsylvania homes cared for children other than those of the patients, or for delinquent girls, or for aged or needy women, in addition to giving maternity-home service, whereas only one of the Minnesota homes cared for children other than those of patients, only one cared for delinquents, and none cared for the other types of persons admitted to the Pennsylvania homes.

Diet.—The food of the expectant mother and the nursing mother is so important to the well-being of the mother and the child that an attempt was made to analyze the diet of the patients in the homes. It is impossible to make a comprehensive study of the efficiency of an institution's dietary without careful measurement of the amount of each food provided and of the amount eaten by individuals; and since this quantitative study could not be undertaken an analysis was made of the menus for a series of meals served to the patients. This gave a qualitative picture of the diet in terms of the use of different foods. It was assumed that the amount of each food served at a meal was the equivalent of an average serving. The diets were graded by finding the average use during the week of each type of food material and comparing this average daily food list with a grading sheet which outlined diets of four different grades. The adequacy of the diets was measured by the extent to which they contained satisfactory amounts of the foods containing "adequate protein," mineral substances, and vitamins A, B, C, and D. Many of the homes reported that an additional amount of food was served to the nursing mothers; for the most part this was milk in some form. In classifying the diets of the homes, therefore, separate grades were given for the diets of pregnancy and lactation.

The following daily food plans were used in grading the diets:

Adequate diet

One pint to 1 quart milk.
One egg.
One serving meat.
One serving leafy vegetable (asparagus, lettuce, greens, cabbage, string beans, etc.).
One serving other vegetable.
One serving potato.
One serving fruit (citrous fruit at least four times a week).
One serving whole-grain cereal.
Four or more slices bread (with butter at three meals).

Probably adequate diet

One cup to 1 pint milk.
One or two servings egg or leafy vegetable.
One serving meat.
One serving other vegetable.
One serving potato.
One serving fruit.
One serving whole-grain cereal.
Bread or other starchy foods, with butter.

Possibly inadequate diet

One-half cup to 1 cup of milk.
One or two servings egg or leafy vegetable.
One serving meat.
One serving potato or other vegetable.
One serving fruit.
Bread or other starchy foods, with some butter.

Probably inadequate diet

Milk in coffee to one-half cup.
One or two servings egg or meat.
One or two servings vegetable or fruit.
One serving potato.
Bread or other starchy foods, with small amount butter or butter substitute.

In both States the diets for expectant mothers fell considerably short of desirable standards. Only one home in Minnesota was classed as definitely "adequate" and none in Pennsylvania. Minnesota, however, had a larger proportion of the homes "probably adequate" in diet than Pennsylvania—2 out of 11 as compared with 1 out of 21 (the diet of 3 Pennsylvania homes was not rated).

In most of the homes of both States the diets of the nursing mothers were not satisfactory. In no Pennsylvania home and in only 2 Minnesota homes was the diet classed as definitely adequate. Diets were graded as "probably inadequate" or "possibly inadequate" in more than half the homes in each State.

It was impossible to determine exactly the average daily consumption of milk by the patients, as the amount purchased by the homes varied from 2 quarts daily in a home having only 4 persons to 57 quarts daily in another where there were more than 300. Furthermore, there was no way to estimate how much the staff consumed, or bottle-fed babies, or the other children, and consequently accurate determination of the amount of milk used by each pregnant woman or nursing mother was out of the question. Every superintendent claimed that differentiation from the ordinary diet was made for a patient when the physician ordered it.

The conclusion was that these diets would be improved if more eggs, spinach, lettuce, kale, and cheese (especially cottage cheese), as well as more milk, were used.

Rest and sleep.—In only two homes in Minnesota and three in Pennsylvania were rest periods provided as part of the regular routine, but in most of the homes in both States they were arranged for any mother who seemed to be in special need of them.

For the most part in the homes in both States plenty of sleep in the open air, another necessity for expectant mothers, was provided

through regulations as to hours of sleep and open windows, but some homes in each State had overcrowded quarters with insufficient air space.

Personal hygiene.—Toilet and bathing facilities were provided in all homes in both States. In all the Minnesota homes the importance of personal hygiene as part of prenatal care was recognized in the requirement that patients bathe at least twice a week; in a few Pennsylvania homes there were no regulations, the patients bathing when they pleased.

Care of teeth.—Care of the teeth, another item accepted as essential, was included in the work of four of the Minnesota and six of the Pennsylvania homes, either in clinics maintained by the home or through provision for outside dental service.

Exercise and recreation.—Opportunity for outdoor exercise and recreation was given in all the Minnesota homes, as they all had grounds or gardens; but more than one-third of the Pennsylvania homes were located in city blocks with only rear yards, so that this important feature of maternity care was not adequately provided.

Mental hygiene.—A happy, cheerful state of mind and freedom from worry are among the essentials for an expectant mother's welfare. The majority of maternity-home patients are under economic and social handicaps which militate against the necessary mental tranquillity; and therefore the atmosphere and spirit of the home, the assistance that it gives a mother in overcoming her disadvantages, the opportunities for recreation, and the assistance that it provides in working out individual difficulties are factors of great importance.

In both States the atmosphere of most of the homes was pleasant and homelike, only one or two exceptions being observed. The day's program usually allowed the patients free time for sewing, reading, or recreation. The majority of homes had dispensed with hard-and-fast regulations; and considerable flexibility was noted in regard to visiting hours, absences from the home, and other matters of daily life, which tended to bring about a more contented and cheerful frame of mind than could exist under inflexible routine and rigidly enforced rules. Well-planned programs of recreation were found, however, in only about one-third of the Minnesota homes, and only about one-sixth of the Pennsylvania homes had either regular or occasional provisions for recreation other than the evening gatherings of the patients under the supervision of a staff member. The fact that a few mothers—about 6 per cent of the total number cared for during the year in Pennsylvania and about 9 per cent in Minnesota—left the homes before confinement indicates a certain amount of dissatisfaction, but other reasons also had a part in their leaving, such as provision made for their care elsewhere or the fact that they had venereal disease.

Confinement and postnatal care.

Adequate confinement care was provided for by the large majority of homes in both States. Half the Pennsylvania homes and about one-third of the Minnesota homes sent their patients to cooperating hospitals for delivery. In these hospitals the obstetrical procedure was "good" or "excellent." Confinement care given within the home

was "poor" in one home in Pennsylvania and in none in Minnesota, and it was "fair" in two homes in each State.

The duration of bedside care in the homes averaged 2 weeks in Minnesota and 14 to 16 days in Pennsylvania. In homes having a sufficient number of assistants to give bedside care an early return of the patients from the hospital is not a matter of serious concern, but in large hospitals with small maternity wards a patient might be sent out too soon and her future health jeopardized. There was considerable difference in the procedure of the homes in the two States in the matter of the time which the mothers spent in the homes after the birth of their babies. In Minnesota practically all remained at least three months because of the requirement by the State board of control that babies of illegitimate birth in maternity homes be breast fed for at least that length of time; but in Pennsylvania wide variations existed in the periods of aftercare of the different homes. About one-fifth discharged the patients any time after they had left the hospital, about one-third endeavored to have them remain during the nursing period, and a little less than half definitely tried to keep them for this period. The length of time patients remained in some homes was influenced by the provision made to assist them after they left, such as hospitalization, rest periods, or continued medical advice.

A plan for further supervision increases the service that a home is able to give by providing more workers instead of more house accommodations. This is well illustrated in the Minnesota policy, under which the county child-welfare boards assume responsibility for the mother when she leaves the home and help in her adjustment in her home county. The difficulties mentioned in the section on prenatal care (see p. 3), resulting from too wide a program of service, lessened the adequacy of postnatal care also in certain homes—particularly those in Pennsylvania.

Infant care.

Care of infants was rated as "excellent" in 3 Minnesota and in 4 Pennsylvania homes, "good" in 4 Minnesota and 16 Pennsylvania homes, "fair" in 3 Minnesota and 3 Pennsylvania homes, and "poor" in 1 Minnesota and 1 Pennsylvania home.

All the homes studied in both States reported that they used a prophylactic in the eyes of newborn babies, but nevertheless in one home in Pennsylvania a nursery was visited in which four of the eight babies had acute ophthalmia.

Breast feeding was recognized in Minnesota as important in the life and health of babies; and the mothers in the homes visited, with very few exceptions, nursed their babies for at least three months. In two homes only were departures from this general practice noted; in these the weaning of babies began at six weeks.

In Pennsylvania all the superintendents stated that breast feeding was encouraged, at least for a short time, the periods varying according to physicians' orders.

In all the Minnesota homes mothers were given some training in caring for their babies; in a few this training was only slight. In 17 Pennsylvania homes the mothers were given careful training in infant care; in the other 7 they received little or no instruction.

General health provisions.

In all but one Minnesota home public-health requirements were carefully observed; not all the Pennsylvania institutions showed the same care. The physical equipment of the Minnesota homes gave them certain advantages over those in Pennsylvania in providing for the general health of their patients. Three-fourths of these had been built particularly for maternity-home use. All but one were rated as in "excellent" condition. Only three of the Pennsylvania homes had been built for maternity-home use. Less than half were rated as in "excellent" condition and most of the others were rated as in "good" condition. It is generally recognized that large dormitories with many beds are not so satisfactory as rooms with only a few patients in each. An acute infection can be controlled far more readily in a room of the latter type than in a dormitory. In Minnesota the proportion of homes having small rooms with single beds was much higher than in Pennsylvania—7 of the 11 Minnesota homes studied as compared with only 1 of the 24 Pennsylvania ones. Several homes in each State had large dormitories which were crowded; in some of the Pennsylvania homes the dormitory beds were so close together that it was hard to pass between them.

In both States the policy of about half the homes was to refuse admission to patients with any communicable disease and to make arrangements for their care elsewhere. Several homes which accepted patients with certain diseases refused to admit those with gonorrhea or syphilis. In Minnesota all the homes which excluded applicants with venereal disease gave sufficiently thorough examinations to make reasonably sure that such cases did not escape detection; some homes required in addition to their own examination a certificate of freedom from disease signed by a member of the State board of health. In Pennsylvania, on the other hand, the inadequate examination might have permitted applicants with venereal disease to enter several homes which had the policy of excluding them. In such cases not only might other patients become infected but the patients with venereal disease would fail to receive adequate treatment. More than half the Pennsylvania homes kept patients in isolation until examination if they could not be examined upon arrival. More than one-fourth made no attempt to protect from infection patients already in the home. In the Minnesota homes which admitted patients with venereal disease there was practically universal practice of public-health measures, such as the provision of individual towels, separate toilets, and separate dishes and drinking cups for such patients; but in Pennsylvania a few superintendents apparently did not recognize the importance of these measures, and their homes did not practice them.

A policy which provides for adequate examination of all patients at the time of admission and the treatment of those afflicted with venereal disease and which assures all other patients security against infection would seem to be the most reasonable and the most widely useful policy for maternity homes to adopt.

A number of homes in Minnesota but only one in Pennsylvania took precautions at the time of admission against other communicable diseases as well as venereal—such as taking throat and nose cultures and vaccinating against smallpox. In all the homes in both States patients suspected of having an infectious disease, other than

venereal, were isolated. Mental defectives were received in all the homes except two in Pennsylvania and one in Minnesota, unless the condition of these patients was such as to make them difficult to manage. Mental defectives were not segregated either in the Pennsylvania or the Minnesota homes that admitted them.

Vital statistics.

The mortality of infants during the first three months of life for the 13 Pennsylvania homes for which the information was available was about twice that which would have been expected both at the rate prevailing in the State as a whole and at the rate prevailing in the entire birth-registration area (32 as compared with 16.6 and 15.4, respectively), whereas the mortality of the group studied in 10 Minnesota homes was approximately one and one-half times that which would have been expected both at the rate prevailing in the State as a whole and at the rate prevailing in the birth-registration area (28 as compared with 18.8 and 20.8, respectively).

SOCIAL DATA

According to the generally accepted standards of child care (see p. 87), children born out of wedlock are entitled not only to the same physical care as children of legitimate birth but also to special social protection which will insure them whenever possible the continued care of their mother, the support of their father, and home life approximating that of the child in a normal home.

Keeping mothers and babies together.

The proportion of mothers who took their babies with them when they left the home was somewhat higher in the Minnesota homes than in the Pennsylvania ones, and a study of placement of babies in free foster or boarding homes from the Minnesota homes and from some Pennsylvania homes showed that in Pennsylvania the babies so placed were separated from their mothers at a much earlier age than in Minnesota. Only three babies under 3 months of age (and they lacked only a few days of that age) were placed from the Minnesota homes, but some 12 days to 3 weeks old were placed from the Pennsylvania homes. The influence of the Minnesota three-months regulation is again shown. In both States the records of a number of homes failed to give adequate information as to what disposition of the babies was made. In both States it was found that very little social investigation was made prior to a patient's admission; only one home in Minnesota and eight in Pennsylvania made any social investigation through staff workers or other social agencies. Only two Minnesota homes and six Pennsylvania homes made use of a social-service exchange. But in Minnesota care and other assistance for all known cases of unmarried mothers were provided for through the system of county child-welfare boards; whereas in Pennsylvania there was no similar provision, and any assistance or supervision provided for unmarried mothers was dependent upon the interest and ability of the individual homes or of private social agencies.

Establishing paternal responsibility.

A comparison of concrete results in establishing paternal responsibility in the two States is difficult because of their different methods

of procedure. In Minnesota the county child-welfare boards were the recognized agencies through which illegitimacy proceedings were taken, and the maternity-home superintendents usually left this matter to agents of these boards, although some superintendents continued their interest and their efforts to induce fathers to meet their responsibilities even after the mothers had left the home. In Pennsylvania there was no agency corresponding to the county child-welfare board, and the policies of the individual homes differed greatly, the majority giving assistance to patients who wished to take action but not taking the initiative in the matter. In Minnesota most of the records of action were filled in by the county child-welfare board, so that the records in the homes did not give complete data on the cases, and in most of the Pennsylvania homes the records were too meager to give conclusive information. However, an intensive study of a limited number of Minnesota cases and of the records of the six Pennsylvania homes (one-fourth of the number studied) which had information on this point indicated that paternal responsibility was fixed by the courts or voluntarily assumed in a much larger proportion of cases in the Minnesota homes than in those in Pennsylvania. In both States the large majority of superintendents and governing boards expressed themselves as not favorable to forced marriages. In only three homes in the two States was there noted an inclination to encourage or insist upon marriage for the sake of the child's name. All others approved of marriage only if it was desired by both the girl and the man.

Placement in foster homes and adoption.

The provision of foster homes and the process of adoption were far more carefully planned and supervised in Minnesota than in Pennsylvania. In Minnesota every foster home had to be approved by the State board of control, and each baby placed was supervised after placement by some responsible child-caring agency. No child could be adopted until after a six-months trial period, and adoption proceedings were subject to regulation by the State board of control. Only three Minnesota homes did their own child placing. In Pennsylvania the placement and adoption proceedings and policies varied with the different homes. Several homes referred to child-placing agencies mothers who wished to place their babies; others placed the children through newspaper advertising or through persons interested in the homes.

About one-third of the Pennsylvania homes delegated the supervision of placed-out babies to children's agencies (not all of which did standardized work). A few did a slight amount of follow-up work; a few placed babies only on condition of their immediate adoption, thus eliminating the necessity for supervision. Adoption proceedings in Pennsylvania did not sufficiently guard the interests of the child or of the mother, and only a few homes followed the example of the best child-placing agencies in requiring a period of residence before adoption. No home of those visited in Minnseota accepted babies on surrender from their mothers, whereas in four Pennsylvania homes the "surrender fees" were one of the sources of income.

96892°—26†——2

CONCLUSIONS

The medical and physical care given mothers and babies in maternity homes and the social provisions made for them after leaving the homes appeared to be much better in Minnesota than in Pennsylvania, although the homes in Minnesota failed to measure up in certain particulars to the accepted standards of care. The system of State licensing and supervision of maternity homes and the relation of the State university's medical school to them tend toward standardization of medical practices in the Minnesota institutions. Through the procedure and policies of the State board of control a baby of illegitimate birth is practically assured of three months' nursing by his mother. This board endeavors also to keep such a baby permanently with his mother, to supervise and help her after she leaves the maternity home, and to obtain for the baby, if possible, his father's interest and support. These efforts by the board are contributing to improved physical care for both mothers and babies and a better social policy in dealing with them.

MATERNITY HOMES IN MINNESOTA

LICENSING AND SUPERVISION

The law of Minnesota defines as a maternity hospital any place operated by an individual, association, or corporation where within six months more than one woman not related by blood or marriage to the person operating such place is received for care and treatment during pregnancy or during delivery or within 10 days after delivery. The code provides for licensing and inspection of all maternity hospitals by the State board of control. Licenses are issued annually, stating the name of the person receiving the license and designating the premises in which the business may be carried on and the number of patients that may be cared for at any one time. The law also provides that no person shall offer to dispose of any child or advertise that he will give children for adoption as an inducement to a woman to go to any maternity hospital during confinement. The statute also provides that a record shall be kept by the licensee of each maternity hospital, to contain the name and residence of every patient and of the physician or midwife in attendance at the birth or at an illness of any child at such hospital. It requires a written report of all such births to be transmitted to the State board of control and of all deaths therein to the local board of health. The contents of these records must not be disclosed except in proper legal proceedings or for the information of the State board of control or the State board of health or the local board of health. Provision is made for revocation of the license by the State board of control if the statute governing maternity homes is violated, or if the hospital fails to have due regard to sanitation and hygiene or to the health and well-being of the patients or the infants born to them, or if any law of the State is violated in a manner disclosing moral turpitude or unfitness to maintain such a place. Provision is also made for appeal from the decisions of the board of control.[1]

The organization of the State board of control provides for a children's bureau with a director and three supervisors. The supervisor of institutions is charged with the supervision of maternity hospitals, the filing of complaints with the board of control in cases in which the provisions of the maternity hospital law are not complied with and the offenders are not amenable to persuasion, and the preparation of such cases for hearing. A certain uniformity in the matter of minimum standards of care is provided in Minnesota by the system of licensing and supervision.

Nearly all the homes have either as attending physicians or as consultants physicians from the medical school of the State university, and the State board of health laboratories also are at the service of the homes.

---

[1] Laws of 1919, extra session, ch. 50.

ORIGIN AND DEVELOPMENT

The 11 maternity homes included in the study were located in four counties. Two of the homes were founded about 50 years ago, one to provide care for needy prospective mothers, married or unmarried, the other to bring about moral rehabilitation. A third home was established about 40 years ago, with the purely humanitarian aim of caring for expectant mothers. Of the other eight, four were founded between 1900 and 1910 and four since 1913. The motives actuating the founders of six of these eight were religious or charitable in that protection for the indigent mother and her child was provided; one was founded for purely commercial reasons; and one is part of a State institution.

The majority of these homes originally admitted all types of women needing maternity care, but since the opening of the State Home School for Girls (which cares for delinquents) many homes have adopted the policy of admitting only young unmarried mothers, considering them the most hopeful type. In some homes where child caring was no part of the earlier work it had gradually been added, and nurseries had been fitted up for the care of younger children. These homes preferred to limit their work to unmarried mothers.

The licensing of maternity homes by the State board of control began in 1918, and during that year 10 of the homes studied obtained their licenses. One was founded in 1922 and licensed in 1923.

The Minnesota homes when visited had the following combinations of service: Two gave maternity-home service only, caring for the mother before delivery and for the mother and baby after they left the hospital (these homes gave no obstetrical service and did not have a separate child-caring department); three gave maternity-home service and also obstetrical care in a hospital within the home but had no child-caring department, except that one cared temporarily for not more than five children; one gave maternity-home service and had also a separate department of child care for children up to 2 years of age but gave no obstetrical service; four gave maternity-home and obstetrical service and also had a department of child care (two of the four were licensed to place children in free foster homes); and one provided care for delinquent girls as well as for maternity cases, using an outside hospital for the obstetrical service. Only one home accepted children other than those of the mothers cared for, and this home functioned as a child-caring home for a social agency to which commitments were made and through which all arrangements were made for boarding children.

Two homes had discontinued child care and child placing in recent years and had delegated these services to standardized agencies equipped for the work. One home had a similar change under consideration.

In every instance the foster homes were investigated by the State board of control through the agency of the county child-welfare boards. If a child was placed by an agency in a home which did not meet such standards as the board approved the child was removed.

Since the Minnesota law providing for licensing and inspecting maternity hospitals went into effect 12 hospitals have been closed by the State board of control. Four of these hospitals had been conducted without a license; four were denied a license on application;

three which had been conducted as licensed hospitals were denied a renewal of the license; one withdrew its application immediately after a visit of investigation by the institution inspector of the State children's bureau.

Three maternity hospitals which had been closed in Minnesota were found to be operating in other States. One of these had been licensed for three years in succession, but the State inspector was not satisfied with the condition and management of the place and finally recommended to the State board of control that the license be revoked. The owner of the hospital did not appear on the date set for hearing. On investigation it was learned that she had moved into another State, where, despite the efforts of the State health officer, she was granted a license to operate a maternity hospital.

CAPACITY AND POPULATION[2]

The homes could accommodate from 4 to 63 women and from 5 to 71 children. The total number of women all 11 places could accommodate was 379; the total number of children, 420. When visited the homes had a total population of 249 women and 295 children. Temporary conditions in 4 homes were to a considerable extent responsible for the fact that the total number of persons being cared for was so far below the number that could be accommodated. In 2 homes the number of persons cared for was small because repairs were in progress. Two other homes were not functioning normally because of reorganization plans incident to change of management.

GROUNDS AND BUILDINGS

GROUNDS

All except one of the Minnesota homes visited were in urban or suburban districts, the one exception being part of a State institution located on a farm. The other 10 were in entirely detached buildings with grounds sufficient to provide some outdoor life for the mothers and babies, these grounds varying from a small suburban lot to a place of 10 acres. The 8 suburban homes provided space for outdoor exercise or recreation, and the 2 city homes had yards around them. Ten homes had equipped the grounds for some form of recreation, and many had vegetable gardens where patients were permitted to work if they were able. A number of places had attractive, well-kept lawns, shade trees, flowers, and shrubbery. One home was opposite a large city park. All forms of farm work practicable for pregnant women and mothers recently confined were arranged for in one home, which was situated on a large farm. At another home, where the grounds included 10 acres, efforts had been made to beautify the place. The house had occupied the place only a year, but already it had a lawn, flower beds, and a vegetable garden from which the table was supplied.

BUILDINGS

The buildings themselves, with one exception, were in excellent condition. The majority were of the congregate type. Two were

[2] Women other than maternity patients are not considered in this section.

on the group or cottage plan, these not having been built for the purpose for which they were used. One of these was soon to be replaced by a building then in process of construction, and another, originally built for use as an orthopedic hospital, had been excellently adapted for use as a maternity home. Thus there was only one institution not well built for its use; this one had no fire protection. The buildings were constructed of frame, brick, or stone, and they varied from two to four stories in height. All were electrically lighted and furnace heated, and seven had supplementary heating arrangements such as stoves, fireplaces, and gas burners.

Of the three homes using the cottage plan, one, the State institution, had five cottages for the maternity group; one had a small cottage adjacent to the main building where girls with venereal disease lived until medical treatment rendered the disease noninfectious; and the third, a hospital with maternity-home provision, had separate buildings for certain children and a special wing for mothers who remained after discharge from the hospital proper.

Ten of the kitchens were on the first floor; one home had a basement kitchen, which was on the ground level in front. All except one were well lighted and ventilated. All were well screened. The dining rooms, except one, were on the first floor, and all were well lighted, ventilated, and screened. Two dining rooms were especially attractive, and only two were not pleasing.

All serving of meals was done by patients. In three homes the members of the staff were served in separate dining rooms and had food different from that served the patients.

As a rule the sleeping quarters were very good. Three homes had rather large dormitories with crowded floor space, containing 7, 19, and 20 beds, respectively. In these dormitories the cubic feet of air space seemed inadequate even though, as was the custom in all these homes, the windows were open at night. Another home had rather small rooms, each containing three single beds. Seven homes had all single rooms with single beds.

Toilet conveniences were provided in all homes, but it was noted that in two homes which received patients with venereal infections no separate toilet arrangements were provided for such patients. Since the visit of the Children's Bureau agents one of these homes has corrected this defect.

Bathing facilities, either tubs or showers, and individual towels were provided, and the patients were expected to bathe at least twice a week. Hot and cold water were always on tap. Ten homes were supplied with water from the city system and one from a gravity tank at a lake. One had a septic tank for sewage; the other 10 used the city systems. Eight had their garbage collected by the city and three incinerated it. The general impression was that in eight institutions the sanitation was "excellent," in two "good," and in one "poor."

ADMINISTRATION

BOARDS

Four of the 11 homes were controlled by local governing boards, the membership of which was self-perpetuating. Three had boards elected by groups interested in the homes. Two had no boards; one

of these was controlled by a national organization. One was part of the State reformatory for girls, which was managed by the State board of control. No data were obtained for one board which seemed to be merely an auxiliary to a charity organization responsible for the home. In all homes having boards the superintendent met with the board.

Two of the seven boards were composed of men only; three, of women only; and the other two had both men and women as members. Four were restricted to their respective religious denominations—of these, one was composed wholly of clergymen.

STAFFS

Much of the good work accomplished by these homes may be attributed to the superintendents. Four of the superintendents were college graduates—one of them a physician. Three were high-school graduates; one was a graduate nurse; and three had only experience and common-school education to guide them, although they could be classed as practical nurses. Their years of work in institutions varied from less than one year to 17 years. Two (members of religious orders) received no salary, and the salaries of the others ranged from $300 to $2,500 a year, with maintenance.

In three homes the superintendent's assistants were chosen by the board of managers; in eight, by the superintendent, subject to the board's approval. There were 85 assistants on the staffs of the different homes, many of whom had had more than an elementary-school education. Eleven in eight homes were graduate nurses, 33 in four homes were undergraduate nurses, and 5 in four homes were called practical nurses. One home employed a social worker.

The number of assistants employed seemed adequate for efficient management and for supervision of the patients except in two homes. In one of these the only assistants were two women, former patients, both of them unmarried mothers who were boarding their babies. Although these women appeared to be capable of executing the duties assigned to them, the practice of leaving one of them in charge of the home during the absences of the superintendent seemed unwise, especially as these absences were frequent and sometimes prolonged. In the other home, a commercial one, the proprietor had no regular assistant but engaged a nurse for a brief period at the time of each delivery. If the proprietor was absent the establishment was left in in the care of certain unmarried mothers whom she employed as a means of assisting them.

In homes where the organization is well planned assistants have definite responsibility for direction of certain parts of the work—both in the management and care of the buildings and in the training of the mothers. With the exception of nurses, physicians, and dietitians, and of trained social workers who worked chiefly outside the institutions—all of whom were part of the staff in a few homes—the preparation of the assistants in the homes studied was practically limited to the experience acquired in working in institutions.

The absence of technical training and of experience in modern methods of social service was, however, less important in the Minnesota maternity homes than in the Pennsylvania ones, because under the Minnesota system all unmarried mothers were reported to the State board of control when admitted to the homes and the county

child-welfare boards assumed responsibility for plans for the mothers and babies and provided necessary supervision after discharge from the homes.

The salaries of the assistants varied from $120 to $1,500 a year, with maintenance.

Additional employees such as gardeners and janitors were not listed as members of the staffs. Every home except one had such help for work too heavy for the patients. In all the homes some of the housework was done by the patients, according to their strength.

FINANCES

One home (part of the State reformatory for girls), which received minors committed to the reformatory if they were in need of maternity-home care, was wholly supported by the State. No private institutions were given State aid. Boards of county commissioners might make arrangements for hospital care for persons residing in their counties. Two of the homes received pay from county boards for maternity cases on a pro rata basis. One home received a fee of $50 a patient from the city for the care of maternity patients who had a legal residence in the city and could not pay for their care. One home received children from an agency which directed its management, work, and policies. One county paid to this agency as well as other agencies a pro rata sum to care for committed children. All the other homes derived their revenue through public appeals for money, unsolicited donations, fees paid by the patients and their families, or endowment funds. Six accepted money for boarding and caring for children.

Eight of the 10 homes supported privately received their funds through community chests in their respective cities. The two exceptions were: One home, founded in 1922, which at the time visited, collected its fund independently but which had been admitted to the community chest for 1924, and one which was a commercial enterprise, depending on patients' fees.

Excluding one institution, a commercial enterprise, the annual expenditures by these institutions varied from $69,000 to a little more than $4,000. The home connected with the State institution did not keep a separate expense account.

RATES AND FEES

All the homes except the State institution had a flexible system of rates which permitted patients to meet all or part of their expenses if they were financially able to do so. One home had no fixed rate or fee but accepted compensation commensurate with the patient's means, if she could pay any amount at all. Six homes charged fees varying from $50 to $100. When these fees were collected amounts of $15 to $35 were sent by the institutions to outside hospitals giving obstetrical care to the home's patients. One home charged $47 for confinement care, plus $12 for use of the delivery room, besides 75 cents a day for the patient's stay in the house before and after the period of care in the hospital ward. One home charged $25 a month for the mother and $5 a month for the baby. Another home charged $30 for confinement care and $10 a week for board before and after the confinement period; and the physician's fee was an additional charge.

These amounts were for the large majority of the unmarried mothers and for married ones whose cases presented such social problems as to warrant their inclusion in the service of the maternity homes. The two hospitals that included maternity-home care in their programs charged for rooms a maximum of $5.50 per day and additional amounts for certain services and for physicians' fees. These services were utilized almost entirely by married women. One of the maternity homes with hospital equipment in the home had a private room for which $2 a day was charged and which was used sometimes by married women in the neighborhood.

INCOME FROM WORK OF PATIENTS

Money was available from the work of the patients in two homes. In one home the work was limited to art needlework and the entire proceeds went to the home. Sales were held twice each year. In the other home there were several courses of training from which revenue might be realized. There was no hard-and-fast rule about the use of proceeds, but the girls usually used part of their earnings for some purpose which furthered the pleasurable interests of their companions. The summer before the investigation the girls in this home had 24 individual gardens with the privilege of raising what they wished, and they used the products of their work as they pleased.

ABSENCE OF "SURRENDER FEES"

The complete absence of the system of accepting babies of illegitimate birth on surrender upon payment of a specified fee by their mothers is noteworthy. To what extent this was due to the attitude of the people interested in the maternity homes and to what extent it was due to legislation by the State could not be determined in this inquiry. The history of the institutions studied—except the commercial institutions—indicated that this system has not at any time been so extensive in Minnesota as in some other States.

INCOME FROM BOARD PAID FOR BABIES

Homes which accepted children for care received a certain amount of income through board paid for them by relatives or other interested persons.

In some of these institutions the amount of income received for the care of mothers was not separate from that received for boarding children, so that it was impossible to measure accurately the extent to which this latter resource met the actual expense of care for the mothers. From conferences with superintendents and from a study of records, however, it would seem that one-half to two-thirds of the entire number of patients paid all or part of the fees for their care. In one home it was estimated that about one-fourth of the patients paid fees.

RECORDS AND REPORTS

All but one of the homes prepared annual reports, but only three printed them.

The State board of control had furnished a form for registering the patients; this was used in all the homes except the maternity department of the State reformatory for girls, which had its own special

system of record keeping. On this form was provided space for the name, date of birth, address, religion, nationality, and occupation of the patient and of the putative father of the child, the date of birth of the child, the date and cause of death of mother or child, the disposition of the child, and additional facts which would serve for purposes of identification. Space was also provided for recording any particularly significant facts in the history of the case. The record of the birth was to be signed by the physician and the nurse attending the case.

In addition to the forms provided, four homes used individual history records, and four others used special record books. For the most part, medical records were well kept and contained all essential data, but there was a lack of the complete health data that might have been recorded under this system. One institution gave an excellent report to the State children's bureau of all health work done for the patients in 1923, including a record of treatments for venereal disease, major and minor operations, dental treatments, the number of persons fitted with glasses or braces, and psychometric tests. Several of the homes had no history of the medical care afforded each patient. All the institutions weighed and measured the babies and recorded the results.

No provision was made on the record for data on morbidity after the puerperium.

ADMISSION OF PATIENTS

SOURCE

Patients were received from social agencies, private and public, and upon their personal application or that of an individual in their behalf. Two homes accepted girls through court commitment—the State institution, and one private home which occasionally accepted a girl from the juvenile court. The commercial home advertised in a local daily newspaper that it gave maternity and child care.

Preliminary social investigation by the home was a requirement before entrance in one home only. A study of the girls after admission through registration of cases with social-service exchanges was made in two homes. Such exchanges were available to five other homes, but they were not used. It was the policy throughout the State for the county child-welfare board to investigate each patient's history after she entered the home. Usually girls entering the State institution through court commitment were investigated by the court. The superintendents of seven institutions showed no reluctance to transfer cases to social agencies having an interest in them.

LIMITATIONS

Race.

Five of the 11 homes visited made no distinction as to the race of the patients admitted; three accepted only white patients; two, although they did not refuse women of other races, limited as far as possible their patients to white women; one accepted patients of any race but the negro.

Religion.

In no institution were religious lines drawn, although in one the management preferred to have only patients of the religious denom-

ination under which the place was operated. The policy here was to refer the application of any person belonging to another denomination to a home conducted under the auspices of that denomination. Such patients were accepted in emergency but were transferred when possible to other homes.

Age.

In the home that was part of the State reformatory the maximum age for commitment was 18. None of the other homes had age limits or restrictions, although several gave preference to young women.

Residence.

Although some of the homes tried to restrict their service to persons living in the State, more than half made no restrictions as to residence. The ruling of three homes was that persons not living in the State would be admitted only as emergency cases, and one of these homes accepted no out-of-State patients unless they were already in labor. Another home did not accept as free cases patients living out of the State, but charged them $100.

Marital status.

In regard to marital status, virtually no lines were drawn except in one institution. Here the original purpose was moral reclamation, and the managing board still felt that unmarried women needed their ministrations most. In 5 of the other 10 places there was no question as to marital status; in 5 the policy was to accept married women for special reasons only.

Delinquency cases.

Only two maternity homes in Minnesota accepted delinquent girls who were not maternity patients. One of these was the State reformatory home; the other was a private home opened in recent years for the care of delinquent girls, which received maternity cases to meet a pressing need in the community.

Pregnancies other than first.

The question whether or not unmarried women in pregnancies other than the first should be admitted for care had been given serious consideration by those in charge of many of the homes.

For years the policy in a majority of these institutions was to limit assistance to unmarried women in the first pregnancy, although some institutions accepted patients in later pregnancies if they had not been former patients of the institution. Some superintendents and board members have felt that they had exerted every effort to assist a mother during her first residence at the institution. If they had failed, or if she had not responded, further effort on their part, they believed, would avail nothing. Others stated that having "repeaters" in the home had a decidedly bad influence on the other patients, particularly when it was known that the repeaters had been in the same institution before. However, a tendency was noted not to have any fixed policy, but to consider each case on its merits.

Three homes received repeaters without question; three received them unless previously cared for in the same home; two would not receive them if earlier pregnancies were known but would keep them if after admission they were found to have had earlier pregnancies; two homes made certain exceptions to their policy of not accepting such cases. The one commercial home which received without

charge a few patients in exchange for housework refused to admit repeaters on this basis, accepting them only as pay patients.

Mental defectives.

Mental defectives were accepted by all but one of the homes, according to statements of the superintendents, some of whom qualified their statement by adding "if they are not too great a problem." They were not segregated.

Communicable disease.

Three homes admitted and isolated patients having any communicable disease, and two others admitted patients having gonorrhea and had provision for treating them, but consistently refused to admit persons having any other infectious disease. All the six homes which refused to admit persons having a communicable disease gave the patients a physical examination upon entrance or detained them in isolation until examination was made. Thus it was reasonably certain that no cases of such disease were admitted. If an infection was found later arrangements were made for the patients to be cared for elsewhere. Four homes required of each patient who entered not only a physical examination but also a certificate of freedom from communicable disease. The superintendents of three of these homes said that they required these certificates to be signed by one of the members of the staff of the State board of health. This procedure was due to the desire to exclude all cases of venereal disease, despite the fact that at least two of these homes had excellent provisions for segregation and treatment of infectious diseases. As a result of this policy these facilities were not used. The superintendent of another home which had every necessary provision for isolating contagious disease said she did not admit patients with either gonorrhea or syphilis; but it was found that such patients were actually admitted fairly often and were well treated, every precaution being taken to protect the other persons in the home from contagion. In most of the homes a marked degree of flexibility was noted in the rules in regard to admitting patients having communicable disease.

DIETS

Menus for a week were obtained from all the homes. The number of meals served during the day varied from three scant ones in a home where the diet seemed insufficient to maintain women and girls in health and where the milk was watered considerably before serving to five a day in some homes. One superintendent stated that the patients could go to the kitchen for food whenever they were hungry. Another was serving water to the nursing mothers because she had heard that it was "just as good as milk." Study of the menus submitted by the 11 homes showed that their diets belonged in the following grades (see p. 5):

	For pregnancy	For lactation
Adequate	1	2
Probably adequate	2	2
Possibly inadequate	5	6
Probably inadequate	3	1

The diets for nursing mothers were better than those for expectant mothers on account of the greater amount of milk given the nursing

mothers. The addition of the milk raised the content of the diet in all three of the factors considered in rating them—"adequate protein," mineral substances, and vitamins. In most of these homes two glasses of whole milk daily should have been added to the diet of every patient.

PRENATAL CARE

The majority of these homes were influenced by the medical principles taught by the medical school of the University of Minnesota. In only one home prenatal care was rated as "poor," in two it was "fair," and in the remaining eight "good" or "excellent." In the home in which prenatal care was rated as "poor" the medical care was painstaking; but the physician's advice was not always carried out by the superintendent, who lacked the training necessary for thorough understanding of the value of prenatal care. One maternal death was directly traceable to the lack of an obstetrical examination. After the death a physician found that the patient had a badly deformed pelvis. No attention had been given her previous to the onset of labor, a very protracted and exhausting labor without the attendance of a physician.

Generally the attending physicians showed keen interest in giving information as to the details of the patient's care, and this interest was further indicated by the almost universal excellence of the medical records kept. A complete physical examination, a Wassermann test of the blood of every patient either before this examination or shortly after it, and a vaginal smear were the customary procedure. This indicated the effort made to safeguard not only the health of the expectant mother but also that of the coming baby and to prevent the spread of venereal disease. This practice probably would have been found in every home had the study been made a little later, for there was only one exception, a home with a new superintendent who was making valiant efforts to interest local physicians in her problem. The former superintendent had been uncooperative and even hostile toward the medical profession.

Two homes required that throat cultures be taken for the detection of diphtheria bacilli; and because of a previous experience with an epidemic of smallpox, three institutions required vaccination also shortly after entrance. One home maintained a dental clinic, and two others engaged outside dentists for any work necessary. One employed a dental assistant for regular oral prophylaxis. Mental examinations of patients were made in only one home.

On the whole, the prenatal care afforded expectant mothers was good. It was not stereotyped but was suited to each individual. As an instance of this may be cited the watching of the increase in weight of the patients during their last six weeks of pregnancy. In one home a physician did this weighing every other day, and finally daily, hoping to prevent too great an increase in the size of the fetus.

Usually special rest periods were provided for nursing mothers and others who needed them. In two places definite rest periods for all patients were provided as part of the routine. All but one home made use of a laboratory, either its own or that of a hospital or clinic. Seven used the State university laboratory for part or the whole of their work.

CONFINEMENT AND POSTNATAL CARE

The equipment for delivery and the technique, so far as it was possible to judge, was "excellent" in four places, "good" in five, and "fair" in two. One of the last two was in charge of a woman who had no professional training but who occasionally delivered the patients herself, and in the other one of the two there was marked lack of facilities for the sterilization of supplies. The average time of bedside care was about two weeks. Patients were sent by four homes to cooperating hospitals for delivery; in seven they were cared for in the home. All had the services of graduate nurses, though two employed these nurses at irregular intervals as they were needed. All homes provided for examinations by physicians at the end of the puerperium, though two did not keep records of them.

INFANT CARE

Special attention has been given the subject of breast feeding in this State, and the proper technique was employed in the maternity homes. The statement has been made that with very few exceptions all mothers can nurse their babies. Nurses whose specialty is instruction in the technique of breast feeding are available to every mother in Minneapolis.

So generally is breast feeding recognized that a section of a joint resolution of the State board of health and the State board of control, adopted in 1918, governing the policy of illegitimacy proceedings, provides: "Because of the very large death rate among children born out of wedlock, the State board of control has ruled that such children must be nursed by their mothers for a period of at least three months and as long thereafter as possible." (See p. 30.) However, in two homes weaning was begun at 6 weeks and nursing gradually decreased, until at 3 months the child was entirely bottle fed. This practice facilitated the separation of mother and baby. With these exceptions breast feeding was found to be almost universal in the homes, the rule being carefully observed.

A prophylactic was used in the eyes of all the newborn infants.

There were no nurseries in four homes; in these homes the babies were kept with their mothers. Other homes had not only nurseries but also solaria, where the babies were placed during the day. In all the homes careful, regular weighing of the babies was done, to note their growth. In two homes for the first two weeks of life all infants were weighed before and after nursing to determine how much breast milk they obtained each time.

In an effort to prevent some neonatal deaths the coagulation time of the blood of all newborn infants was recorded in two homes, and if necessary treatment was instituted.

Some training in the care of their infants was given to all the mothers, but this seemed rather desultory in some homes. Each institution reported that all births were registered.

The care of the infants was rated as "excellent" in three homes, "good" in four, "fair" in three, and "poor" in one.

OBSERVANCE OF PUBLIC-HEALTH MEASURES

All the homes except one carefully observed all public-health requirements. Their attitude of cooperation was doubtless due to the relation of the State board of health to the child-conservation program.

VITAL STATISTICS

During 1922 in the homes studied or in the hospitals cooperating with them 1,151 live births and 29 stillbirths occurred and 2 maternal deaths. Among these infants 44 deaths were recorded. It was not possible to calculate a rate from these figures in the absence of information as to how long the infants stayed in the homes. For 10 homes it was possible to make a comparison between the number of infants exposed to the risk of dying in the first three months and the number that died. Comparing the mortality in the homes as calculated by this means with the mortality in the State and in the birth-registration area it was found that the number of deaths in the homes was 28 as contrasted with 18.8 that would have been expected at the rate prevailing in the State as a whole, and with 20.8 that would have been expected at the rate prevailing in the entire birth-registration area.

ROUTINE AND REGULATIONS

The daily routine in most of the homes centered around the work of the institution, and housekeeping tasks assigned to the patients by the members of the staff occupied the larger part of the day. Patients rose between 6 and 7 o'clock in the morning; and the meal hours were about 7, noon, and half past 5.

Care of the babies was one of the first duties in the order of the day. Most mothers received training in this and gave most of the care to their own babies. Generally part of the afternoon was devoted to sewing. Five homes had arranged classes in hygiene and other subjects, and these were held in the afternoons or evenings. Three homes had a well-planned day, and in two of these the daily schedule was always displayed.

The gradual disappearance of the formidable posted regulations formerly in general use is encouraging. Not a single instance of these was found in the 11 homes studied in Minnesota. In several institutions there were certain specific regulations such as those on sanitation and hygiene which were found posted in certain parts of the building, but these were more in the nature of a guide and a help to the girls than of "rules."

Six of the homes had a general visiting day; four had flexible rulings which practically permitted authorized visitors at any time except during hours which were utterly inconvenient for the home; and one allowed each girl to select one day a month for her visitors.

The private maternity homes in Minnesota were found in a number of instances to be permitting their patients all the freedom which might be granted with due consideration for the well-being of the institution and the patients. The management in five of the

homes still felt it necessary to provide chaperonage by staff members for patients at all times. Four homes have had very little restriction; older patients who have proved trustworthy, as well as volunteer social workers, were utilized as chaperons. Patients who were believed reliable were allowed frequently to go alone to their respective churches for morning services and occasionally to go out on necessary business errands. In general these homes planned that when the girls went out for shopping or recreation a group of them, or at least two, should go together. In one home the degree of freedom permitted was so extreme as to be unwise. This was a small place where no restrictions were imposed except that certain patients who gave their services in exchange for care and shelter were obliged to complete their work before going out; they were allowed to remain out until 11 p. m. A local social worker related instances of associations and conduct on the part of unmarried mothers from this place which indicated at least the grave danger of abuse to which such a policy is subject.

The almost universal policy of such institutions has been to censor all incoming and outgoing mail. In this detail, as in other practices, a gradually crystallizing sentiment was noted in favor of greater freedom for the individual. In several of the Minnesota homes mail was not censored, but certain devices were employed to provide some supervision. In one home the girls were called to the office and given their mail individually. Almost invariably the girls opened these letters there, and often they discussed the contents of them with the social worker.

TRAINING FOR FUTURE EMPLOYMENT

Classes of various sorts—six-months courses for the training of nursery maids, instruction in infant care, sewing, cooking, dressmaking, etc.—were held in several homes. Every home provided some experience in household work or other work under supervision for most of the mothers. Two homes had domestic-science courses. In some homes cooking was not taught. In all the homes patients were taught how to care for their babies. and they cared for them during all or part of the time. One home provided excellent courses of training by utilizing the resources of public departments and other agencies. Teachers were supplied by the extension division of the State university. As a result of a course in poultry raising the patients in this home had a plentiful supply of eggs and fowl. One girl raised 17 chickens. She took these with her when she returned to her parents' farm and was able to make a start in the poultry business. In one home teachers from the State department of education gave various courses. This home had also a training class for nursemaids. Three unmarried mothers, cared for in the home, who had been accepted in this training class were seen at dinner with the staff. Their acceptance as staff members was very significant. At one place instruction to a class was given by the Red Cross in home hygiene and care of the sick, and a small group of girls attended an outside business course in preparation for future work. One unmarried mother, who had been trained as a practical nurse, was earning a good salary.

RECREATION

The recreation in some of the homes was carefully planned and supervised, and in others it was not. Organizations such as the Big Sisters planned entertainment at frequent intervals for patients in two of the homes. Nearly all the homes had phonographs and pianos. Musicals, parties, and various entertainments were provided by outsiders and developed among the patients. The usual time for recreation was the evening. In homes which gave more than the average attention to recreation a portion of certain afternoons was also left free from duties. In one home staff members rotated in taking general responsibility for organizing and supervising the recreation. Four homes had excellent programs, well organized, showing utilization of various resources and the cooperation of the Big Sisters and other volunteers. Picnics, various trips of interest, drives, walks, parties in the homes of friends of the institution, motion pictures, plays, and concerts were all part of these programs. Usually a small group of girls was accompanied by a volunteer worker. In four homes there was no planned program except group recreation inside of the building. In one small home the patients were left to their own devices; this is the place previously referred to which permitted the patient the entire evening free.

Several homes were equipped with good books, but the use of books from a city library was rare.

SPECIAL PROVISIONS IN MINNESOTA FOR UNMARRIED MOTHERS AND THEIR CHILDREN

The attitude of the State Board of Control of Minnesota, as well as that of the groups who were responsible for the State's child-welfare legislation and the resulting system of child care is that the peculiar danger to which children born out of wedlock have been subject in most places, the high death rate among them, and the unfortunate results of efforts to maintain secrecy about their birth all constitute reasons for special procedure, special plans for their protection, and continued supervision.

RESPONSIBILITY OF COUNTY CHILD-WELFARE BOARDS

County child-welfare boards are provided for in the law which defines the functions of the State board of control in regard to the supervision and care of children. These boards touch closely the work of maternity homes and community problems related to it. They are in contact with all known cases of illegitimacy in their county, either through a member of the board designated by the board as secretary or through their executive secretary; they supply service such as relief or temporary case work; they are recognized by the county attorneys and the courts as the agency through which proceedings to establish paternity are instituted, and orders for support usually direct that the money be paid through their office. They help in the adjustment of the unmarried mother after she leaves the maternity home and any plan made for her must have their approval. Preparation for meeting her needs is usually made before

she leaves the maternity home. Soon after her arrival in the county where she is to live a representative of the board of the county calls to see her and her baby. The mother has been prepared for the call, and understands that through the board's representative she may be helped to solve her problems. If the mother remains in the county where the maternity home in which she received care is located, she will have already met the representative of the board, because all patients while in the homes meet the representatives of the boards of their respective counties. These representatives make investigations, formulate plans, and give to the mothers the assistance which prepares the way for them and their children either directly or through the superintendent or another worker of the home. A report to the State board of control of all children born out of wedlock is required and this is an important safeguard against the disappearance of the children. Provision is made for a permanent file of all cases handled by the various county child-welfare boards. Duplicates are made of all case histories in the offices of the county boards. Originals remain in the county offices; the copies are fowarded to the children's bureau of the State board of control and there kept on file. The State children's bureau notifies the county child-welfare board of the removal of a child of illegitimate birth from the county where it was originally cared for, advising also the board in the county into which the child is taken. When a child leaves a county the record in the office of that county board is closed. The State children's bureau in reporting the case in the second county passes on to this board the information with reference to the child and the mother.

Provision for the establishment of these boards was made in 1917. The directory published by the State board of control in 1923 shows that 67 of the 81 counties of the State had organized boards and that organization or reorganization was pending in 4 other counties. Seventeen of the 67 county boards had executive secretaries. Some of them gave full-time work and others part time, the part-time workers being engaged by the Red Cross. In all the counties of the State there are nurses (and in some, probation officers) whose services are utilized by the county child-welfare boards.

ESTABLISHMENT OF PATERNITY

A Minnesota statute makes it the duty of the State board of control to see that steps are taken to establish the paternity of children of illegitimate birth and that there is secured for such children the nearest approximation to the care, support, and education that they would be entitled to if born of lawful marriage.[3] Administrative procedure under the law includes private hearings and affords privacy to the whole matter, through the functioning of the county child-welfare boards. A warrant is given the representative of the board, who interviews the putative father and gives him an opportunity to come into court without arrest. By statutory provision[4] transfer of guardianship of a child under 14 years of age is a matter of court record, and it may not be informally executed with a mere written surrender. Thus legal record, which is familiar in all States in regard to the transfer of ownership of property, is required in Minnesota for the transfer

[3] Laws of 1917, ch. 194, sec. 2.
[4] Laws of 1919, extra session, ch. 51, sec. 2.

of guardianship of children under 14. Such legal recognition is not in all States a necessary condition in the acceptance of children by individuals and institutions for placement away from their relatives.

PLACEMENT IN FOSTER HOMES AND ADOPTION

Whenever a child has to be placed an effort is made by the State board of control to have him committed to an agency which has been certified by the board as a proper placing agency. This agency, after investigation, selects a family home, places the child in it, and reports the placement to the board, which then sends an agent to visit the home, and if the report is satisfactory approves the placement. By law the placing agency is responsible for supervision of the child in the foster home until adoption takes place or the child reaches his majority. Inasmuch as most of the babies and very young children placed in foster homes are legally adopted, usually the children need not be supervised for a long time. The law also requires that the child remain in the home six months before adoption may take place, unless this requirement is waived by the State board of control or by the court.

Every petition for adoption of a minor child must be reported to the State board of control by the court in which the petition is filed. The board must then investigate the child's history, judge the fitness of the proposed foster home, and make reports and recommendations to the court.[5] Permission of the State board of control must be obtained in order to place a child outside the State.

SUPERVISION OF CHILDREN'S INSTITUTIONS, OF BOARDING HOMES, AND OF CHILD-PLACING AGENCIES

The State board of control is authorized by law to license and supervise all child-placing agencies and institutions and all boarding homes for children. The law also provides that the board shall have committed to its guardianship all persons adjudged feeble-minded, with power to commit such persons to an appropriate institution or to exercise general supervision over them anywhere in the State outside an institution.[6] This system makes possible the specialized, individual treatment of certain cases in family homes, a method which has been tried successfully in certain places in this country in recent years, and which has been in use in some European countries with satisfactory results for a number of years.

The work of supervision and investigation of mentally defective children placed in family homes is delegated by the State board of control to the county child-welfare boards.

DISCHARGE AND CONTINUED SUPERVISION OF PATIENTS

Inasmuch as the policy of the homes, growing out of a ruling of the State board of control, influenced the patients to nurse their babies for three months after birth, the mothers and babies usually remained at least that length of time in the homes.

Of more than 600 mothers cared for in the 11 homes—that is, the total number to whom maternity-home service was extended, exclusive of purely obstetrical patients who were all, as far as was known,

[5] Laws of 1917, ch. 222.
[6] Laws of 1923, ch. 260.

married women—55 left the institution prior to delivery. The reason given for their leaving was either that provision had been made to care for them in their own State or county or that they were venereal-disease patients and had to be cared for elsewhere.

An average period of care of four months and three days was estimated for all the mothers who were cared for in nine of the homes. Records of individual patients were used to obtain these data. It was necessary to eliminate the data on two places because in one, a small home, the date of discharge was invariably omitted from the record, and in the other, the State institution, all patients had been committed, and parole was granted to most of them after 18 months.

The supervision of the mothers and babies by the county child-welfare boards after discharge from the homes did not entirely preclude further contact with the institutions and follow-up by them. One home made an effort to keep in touch with each mother for at least one year after discharge, but the follow-up by most homes was rather general; sometimes it was merely an incidental contact. Usually it depended on relations which had developed between workers in the homes and their charges. Several homes, however, had organized associations to foster the tie with the girls. Most of them encouraged return visits, one home even providing a bedroom which was kept in readiness for these visitors.

PROVISIONS MADE FOR BABIES

GENERAL STATEMENT

Omissions in the records of patients, particularly in regard to provision made for their babies, were noted in several homes. The records of one home in which only a small number of patients had been cared for showed no information on the disposition of the babies born there. In one where 43 patients had been cared for information on the disposition of the baby was omitted in 15 cases. Records of 92 cases in one home showed 30 omissions of this point.

Although the minimum age for separation of babies from their mothers was usually 3 months on account of the State board of control's regulation which insured a start of breast feeding for babies born out of wedlock, a few instances were found in which earlier separations had been effected. These had been consented to by the county child-welfare board, and the records showed reasons for the action taken. Of 58 babies known to have been placed in boarding homes 2 lacked a few days of being 3 months old; the age of the others ranged from 3 months—at which age 37 were boarded out—to 8 months. Of the 37 placed in free foster homes for adoption 1 was under 3 months of age (2 months and 19 days); 21 were 3 months; and 15 were 4 months to 10 months of age.

CASES STUDIED OVER PERIOD OF ONE YEAR

In order to ascertain the extent to which the plans for care of the babies were influenced by the policy of keeping together unmarried mothers and their babies, 185 maternity-home cases were selected at random for study, and their records were studied throughout the first year of the child's life. These records were examined in the files of the county child-welfare board which originally had super-

vision over the child and, if the child had been taken during this period from one county to another, in the files of the second county's board. If it was not possible for the investigator to go to the county into which the child had been removed the records were examined in the files of the State children's bureau. This study, although necessarily small, is an index to the results which may be obtained by such a centralized State case-working department as is found in Minnesota.

These records were studied to learn the status of the mother and baby on discharge from the maternity home, usually when the baby was 3 months old, and also at the end of the first year of his life, or at the time of the last information in the record. They were studied also to learn whether any effort had been made to fix paternity and what had been the result of this effort.

The records showed the following status of mother and baby at the time of discharge from the maternity homes:

1. Twenty-two mothers had left the homes before delivery.
2. Eighteen babies had died before their mothers left the home or were stillborn.
3. Forty-four babies and their mothers were living with relatives.
4. Eleven mothers had married and were keeping their babies with them. Ten had married the fathers of the babies; one, another man.
5. Twenty-three mothers had obtained domestic positions and were keeping their babies with them.
6. Six babies and their mothers were living in maternity homes other than the first home in which they were cared for.
7. Two mothers had been committed to the State reformatory for girls and were keeping their babies there.
8. Twenty-eight babies were boarded—26 in family boarding homes and 2 in institutions. The mothers paid the board or part of it.
9. Eight babies had been placed for adoption.
10. In 23 cases the status was not clear.

The records showed the following status of mother and baby at the end of the first year of the child's life or at the time of the last information in the record:[7]

1. Fifty-three babies and their mothers were living with relatives.
2. Twenty mothers had married and were keeping their babies with them (15 had married the fathers of the babies; 5, other men.)
3. Six mothers had obtained domestic positions and were keeping their babies with them.
4. Five babies and their mothers were living in maternity homes other than the homes in which they were first cared for.
5. One mother had been committed to the State reformatory for girls and was keeping her baby there.
6. Twenty-four babies were boarded away from their mothers—22 in family homes, 2 in institutions. The mother paid the board or part of it.
7. Twenty-seven babies had been placed in foster homes, legally adopted, or committed to placing agencies or institutions.
8. One baby had been committed to a State institution as mentally defective.
9. Seventeen babies had returned with their mothers to other States.

[7] In 41 of the 185 cases the last information was entered before the child became 1 year old.

10. Eleven mothers had disappeared before delivery and had not been located. Probably they had left the State, as they were residents of other States.

11. Nine babies had died since discharge from homes.

12. In 11 cases the status was not clear.

The difference in the figures at the time of discharge and at the end of first year of the child's life for children who had been placed out or who were in homes of relatives, for mothers who married during that year, and for mothers in domestic positions is of particular interest. It indicates the advantage of procedure which is not hasty in planning the permanent disposition of these children. The findings in regard to placements of the mothers who had entered domestic service and were keeping their babies with them seem to indicate a certain degree of instability about such an arrangement. It is probable that the reduction from 23 to 6 in the number of mothers in this occupation between the time of discharge and the time their babies became 1 year old may be due to the fact that a considerable number of mothers used this resource through the nursing period and followed other plans later. The increase from 44 to 53 babies in homes of relatives may be due to the increased affection for these children resulting from contact with them, which would not be possible unless mothers retained custody of them. The increase in the number of marriages and in the number of placements in foster homes indicates again the need for looking ahead in making plans for these babies.

Efforts to fix paternity.

Inasmuch as the county child-welfare boards were the agencies through which all action to establish paternity was taken, the records of the maternity homes did not always contain the history and results of these proceedings. Many of the mothers left the homes between the time when such proceedings were started and the time when the decision was given by the court. Because final action was determined by the county child-welfare boards various policies were noted in the work of the homes in different counties. Some superintendents endeavored to reach the putative father and to induce him at least to see the mother and the baby; they achieved excellent results in certain instances. Other superintendents preferred to leave the matter to the agents of the board. In view of the system, it seemed best not to attempt to interpret the interest and activities of these institutions in this regard. The description of Home I (see p. 33) shows clearly the excellent possibilities provided by the Minnesota law. It indicates the general attitude of the courts and it shows what a careful approach to the problem of the compensation due the child from his father can accomplish.

Intensive study of the 185 individual case records in the office of county child-welfare boards and of the State board of control to ascertain the history of the child through the first year of his life gave a fairly good idea of the progress in the State of the work of fixing paternal responsibility. The study showed that in 63 of the 185 cases paternal responsibility was fixed upon the fathers of the children or assumed by them; that in 39 of the 63 cases paternity was established in court; that in 10 agreements were reached, 2 of which were approved by a court, the mothers having married

other men; and that in 14 the parents had been married before action was taken to compel the men to support their children. In 2 of the 39 court cases no orders were entered by the court because the men had been sentenced on other charges. The orders entered in 37 cases varied from $10 to $25 per month, besides amounts of $50 to $150 for confinement expenses. Eight of the agreements were entered into directly by the mother or some of her relatives, contrary to the usual method in Minnesota. Since these mothers were unwilling to take formal action through the usual method of court procedure, these cases were left in statu quo by the county boards. This policy has been worked out in accordance with the attitude of public officials, from the angle of protecting the interests of the mother and the baby. Of these agreements 1 was for a monthly payment of $15 and 9 for settlements of $100 to $1,500. The cases in which small amounts were paid were those in which only the confinement expenses of the mother were met. Most of the babies in these cases had died. In 44 cases reasons were shown why paternity could not be established and in 78 cases no information was given.

DESCRIPTIONS OF INDIVIDUAL HOMES[8]

Home I

This institution was in a good residential section of a city. It had four separate buildings and its grounds occupied 4 acres. These grounds included lawns, recreation grounds, and a garden which supplied the home with fresh vegetables. The four buildings were: A modern maternity hospital with every facility for medical and surgical care, a cottage which served as a home for unmarried mothers, a boarding home for well babies, and a small bungalow equipped as a pediatric building.

The institution was founded more than 35 years ago to meet an imperative need for care of pregnant women, married and unmarried, which the regular hospitals of the city were not prepared to give. It was incorporated in its threefold form—mothers and babies' hospital, home for unmarried mothers, and boarding home for babies—with control vested in a board of directors made up of women. The direction of the institution was in the hands of the superintendent, a woman of training and experience in social work. The members of the resident staff assisting the superintendent who had to do with unmarried mothers and other cases requiring social service were: A director of social service, a resident physician, a superintendent of nurses, a dietitian, a housekeeper, three dormitory supervisors, and a group of graduate nurses and student nurses. The physician, who was a young woman experienced in the best practices in obstetrics, and the other workers in every department not only had been excellently trained but showed understanding of maternity-home work. An example of the service given is the fact that the patients might have the house physician see them at any hour of the day or night.

General supervision of the work was given to this home, as to all such institutions in Minnesota, by the State board of control. The board granted three licenses to this institution for the three types of work carried on: A license for a maternity hospital, one for an infant home, and one for a child-placing agency.

Funds for the work were obtained from the money paid by patients, and from subscriptions raised by the community chest.

The plan of work indicated a desire to render almost any service which might be required for the well-being of a maternity case. The home provided care for charity patients and for patients who could pay for private rooms, and between these two extremes was a large group of patients, both married and unmarried, who were able to pay a moderate amount and desired to do so, but were unable to pay usual hospital rates for any length of time. Arrangements as to the amount to be paid were made through the social-service department of the home.

[8] Two of the homes visited were in process of reorganization and no description of these has been included.

Private patients paid from $3.50 to $5.50 per day plus $12 for dressings and use of delivery room. Other patients were charged $47 for hospital care, which was usually for a 14-day period, and 75 cents a day during the time before and after the period of hospital care. The actual expense of the prenatal and postnatal care was estimated at $2 a day, so that each patient cared for at the reduced rate was expected to contribute service to the routine work of the home while physically able to do so. This was explained in the agreement signed by these patients on admission.

The total number of beds was 63 for adult patients and 80 for children. The beds for adults were divided as follows: 37 for hospital care, 10 for expectant mothers, and 16 for mothers after delivery. Those in the last two groups were usually used by unmarried mothers, many of whom for social reasons required shelter and care for varying periods of time both before and after delivery. Few married women remained for aftercare, as most of them did not need social assistance.

All types of maternity patients were accepted except two—those who had a communicable disease and unmarried women in pregnancies other than the first. Since the maternity hospital did not receive for prenatal care patients who had gonorrhea or syphilis, each applicant for admission was obliged either to bring with her a certificate from the State board of health that she was free from venereal disease or to be detained in isolation at the hospital until a split Wassermann test was made. If the test showed venereal disease the patient was transferred to some other institution for treatment. If found free from venereal disease the patient was then segregated and placed under observation until it was decided that she was free from all other infectious diseases. No one suffering from any constitutional disease was admitted to the cottage with the other pregnant women.

A thorough physical examination was made with a view to detecting focal infections, dental caries, or any other defect that could be treated at this time. Dental service was given at outside clinics. Other corrective work was done if necessary. The house physician had a small laboratory equipment, and the home might also have work done at the city laboratory and the State university laboratory.

During the last six weeks of pregnancy the patient was especially guarded. She was weighed twice weekly, and the amount of carbohydrates in her diet was regulated by her variations in weight. Urinalysis was made at the hospital. Complete records of all examinations were kept.

The house physician delivered the patients, and consulting specialists from the medical school of the State university gave assistance whenever it was needed. The hospital chart for each case was made plain for the visit of the physician by colored graphs which indicated the condition of the patient and gave also a record of the nursing of the baby. Convalescence was safeguarded very carefully, the patient remaining in the hospital an indefinite period of time, according to her condition, and special vigilance was maintained for any evidence of low-grade infections. Isolation with special nursing care was provided for the patient if abnormal temperature, offensive lochia, or any other symptoms indicated that it was needed. During the latter part of the hospital period patients were placed in a solarium where sunshine and fresh air might contribute to their complete recovery.

Coagulation tests were made of the blood of every newly born infant as a precaution in case of hemorrhagic diseases. Breast feeding was the rule, as in all other Minnesota institutions, and manual expression of the residue of milk was taught the mother. Every infant was weighed before and after each of three feedings daily and the amount of milk taken at each feeding was indicated on colored graphs. Thus it was determined whether complementary feeding was necessary. In suitable weather the babies were kept in the open air in baskets under a canopy with a net over each. After leaving the hospital the patient might return to it with her baby for any necessary treatment. A pediatrician visited the hospital nursery three times a week.

Of the 80 beds for children 37 were in the hospital nursery for the babies of patients; 16 in the department of aftercare; 18 in the boarding home, where children under 4 years of age might be given temporary care as a means of help to the mother, and 9 in the pediatric building. Any married woman while a patient in the hospital might have a child under 2 years of age cared for in the boarding home, free or at board as the patient's circumstances warranted. After the discharge of the mothers, babies were sometimes retained in the maternity

home for a period of time arranged by the social-service director and the superintendent of the hospital, either free or at board—a service utilized chiefly by unmarried mothers. Children under 4 from sources outside of the hospital were accepted at board, especially medical cases. The boarding home was also the receiving place for babies who were committed to the maternity hospital. Some babies born in this maternity home were accepted for placement in foster homes. The pediatric department was of particular value in relieving the boarding home of sick babies.

This institution was the only one studied where the diets for both the expectant mothers and the nursing mothers were rated as "adequate." In addition to three meals a day nursing mothers might have two lunches of milk and crackers if necessary. The physician and the dietitian worked together, and the diets were varied to suit the needs of the individual mothers.

The menus for a week are given to illustrate the generous use of vegetables—especially leafy vegetables—and the use of milk, eggs, and cheese in cooking. All these foods could be used equally well in less elaborate menus.

Menus for one week

Monday:
- Breakfast—Poached eggs, toast, pear sauce, coffee.
- Dinner—Ham (baked), corn on cob, escalloped potatoes, cabbage salad, gingerbread with whipped cream.
- Supper—Stuffed baked potatoes (meat and potatoes), "butterfly" salad with mayonnaise dressing, frosted cookies, sauce, coffee.

Tuesday:
- Breakfast—Peach sauce, cereal, toast, coffee.
- Dinner—Hamburger steak, buttered carrots, mashed potatoes, beet pickles, tapioca.
- Supper—Egg and lettuce salad, bran muffins, pear sauce, coconut cake, coffee.

Wednesday:
- Breakfast—French toast, cereal, apple butter, toast, coffee.
- Dinner—Roast veal with dressing, riced potatoes, stewed tomatoes, peach salad with date in center (black-eyed Susan), apple pie with cheese.
- Supper—Welsh rabbit on toast, combination salad (lettuce, cucumbers, tomatoes), gelatin, drop cookies, coffee.

Thursday:
- Breakfast—Scrambled eggs, stewed apricots, toast, coffee.
- Dinner—Meat pie, boiled potatoes, head-lettuce salad with Thousand Island dressing, creamed string beans, prune whip with custard sauce.
- Supper—Sardine-salad sandwiches, radish and lettuce salad, apple snow, vanilla wafers, coffee.

Friday:
- Breakfast—Pancakes, stewed prunes, toast, coffee.
- Dinner—Baked trout, escalloped potatoes, Swiss chard, tomato and bean salad, chocolate pudding.
- Supper—Creamed salmon on toast, cheese salad, Bavarian cream, chocolate cake.

Saturday:
- Breakfast—Milk toast, jam, toast, coffee.
- Dinner—Roast beef, browned potatoes, buttered peas, apricot and coconut salad, caramel custard.
- Supper—Spanish rice, cottage-cheese salad, muffins, sherbet with vanilla wafers, coffee.

Sunday:
- Breakfast—One-half orange, cereal, toast, coffee.
- Dinner—Chicken, riced potatoes, carrots and peas creamed, pineapple and tomato salad, raspberry shortcake with whipped cream.
- Supper—Cold sliced meat, potato salad, pickles or relish, cake, cherry sauce, coffee.

(The patients on a light diet had soup—cream soup, chicken broth, beef broth, etc.—with the addition of macaroni shells or alphabets, eggs, fish, chicken, sweetbreads, etc.)

The following is an outline which the hospital gave as the daily routine of health supervision:

"All prenatal cases are allowed to work from 7.40 a. m. to 10.30 a. m. and from 2 p. m. to 4 p. m. unless otherwise ordered by physician in charge. Weekly examinations are made and close observation of their general health habits.

"Girls are taken to the hospital proper as soon as labor begins and are kept there through confinement and two weeks after. Third week after confinement they are allowed to go to meals but are carefully watched and allowed to do no work that will necessitate their being on their feet. They may do such work as making dressings and sewing, but only for short intervals. During this third week they are also taught the proper care of the child, having complete demonstrations in bathing, weighing, dressing, and the giving of fluids, etc. They are also taught to take temperatures and the importance of daily bowel movements. Breast expression is taught them while they are still in the hospital.

"All babies have a complete physical examination at least once a week, and any unusual symptoms are brought to the notice of the pediatrician in charge, who makes at least three calls a week. Graphic charts are kept on all babies, and the girls are taught the importance of daily gains."

Cooperation with all public-health regulations is the rule, and insistence is made upon further measures, such as vaccination, which are not required by State law. A notable health rule provided that visitors to the nursery must cover their clothing as a precaution against bringing in germs.

Individual records of patients were kept in the regulation maternity register prescribed for use in all maternity hospitals by the State board of control, and additional records for all social-service department cases were in the form of social histories in narrative form chronologically arranged. These were placed at the disposal of the Children's Bureau investigator, and the histories for one year were studied. Of the 90 new maternity patients known to the social-service department 16 were married and 74 unmarried. Nine of the latter left the home before delivery, leaving 65 patients who needed more or less intensive social service. A brief summary of the findings in these 65 histories follows.

As part of the institution's efforts to fix paternity during the year for which the records were studied action was taken in 38 of the 65 cases, either through court procedure or by private approach to the man involved, with these results: 7 marriages; 17 court orders and agreements for support, varying from actual expenses paid where the baby had died to an average of $20 per month; 1 settlement for $3,000; 1 dismissal by court; 5 decisions pending in court; 7 cases in which the result was not stated, 6 of these 7 being cases which the county child-welfare board handled without reporting the result to the hospital social-service department.

The average period of care in the home for these patients was 3 months and 20 days. Twenty-four of the 65 mothers left the hospital without their babies, 3 babies having died and 1 having been stillborn. Of the remaining 20 babies 9 were retained in the boarding home (6 at board and 3 free), and 9 were accepted for placement in free foster homes. The minimum age at separation, for any reason, was 3 months, and the maximum age, 8 months.

All ward patients and all patients admitted to the department for expectant mothers and the department for aftercare were seen by the social-service director, who utilized community resources in formulating plans for them. Patients whose needs required the service of the aftercare department were asked to sign a simple agreement setting forth the mutual obligations of the home and the patient, providing a promise of three months' nursing of the baby, if possible, and making clear what the patient had a right to expect, as well as the rights of the home. A valuable contribution was the service of volunteer workers who provided recreation, did follow-up work after discharge, acted as chaperons when such service was needed, and assisted patients to find suitable employment. The Big Sisters did much of this valuable service. In the daily routine care was taken to provide the kind and amount of work suited to the individual patient; rest and recreation were provided; a plan of health supervision was posted, together with a schedule of activities by means of which an orderly routine was maintained, while at the same time the arrangement was conducive to satisfaction and profit for the patient.

The schedule of activities was as follows:

6 a. m. Rising hour.

7 a. m. Breakfast (all patients must be fully dressed).

A. Laundry workers:

7. 30 a. m. Bathe and weigh babies. (Under supervision of nurse, each baby is examined daily for rash, sore mouth, or any unusual symptoms.)
8. 30 a. m. Make beds, put rooms in order, and see that babies' beds are in order and have clean linen.
9. 00 a. m. Nourishment for mothers.
9. 50 a. m. Nurse babies. (All babies are nursed 20 minutes, unless mother is otherwise ordered by physician in charge. Babies are weighed before and after nursing. All mothers are required to express remaining milk after each nursing and the breast milk thus obtained is used to complement the food of babies needing it.)
10. 30 a. m. Babies are placed in baskets and put out of doors if weather permits.
10. 30 a. m. Report for duty in laundry.
12. 00 noon. Dinner.
1. 00 p. m. On duty.
1. 50 p. m. Nurse babies (same as 9.50 a. m.).
2. 30 p. m. Free for rest or recreation.
3. 00 p. m. Nourishment.
5. 30 p. m. Supper.
6. 00 p. m. Nurse babies.
7. 00 p. m. Prayers.
9. 00 p. m. Nourishment.
9. 45 p. m. Nurse babies.
10. 15 p. m. Lights out.
2. 30 a. m. Nurse babies (all babies under 2 months).

B. Second cook:

6.30 a. m. On duty.
9.00 a. m. Bathe baby (as in "A").
9.50 a. m. Nurse baby (as in "A").
10.00 a. m. Nourishment.
10.30 a. m. On duty.
1.00 p. m. Rest.
1.50 p. m. Nurse baby.
2.30 p. m. Free for rest or recreation.
3.00 p. m. Nourishment.
4.00 p. m. On duty.
6.00 p. m. Nurse baby.
Rest of day. Same as in "A."

C. Pantry maid:

6.00 a. m. On duty.
8.00 a. m. Bathe baby (as in "A").
9.00 a. m. Nourishment.
9.50 a. m. Nurse baby.
10.30 a. m. Nurse baby.
11.00 a. m. On duty.
12.00 noon. Dinner.
1.50 p. m. Nurse baby.
2.30 p. m. Free for rest or recreation.
3.00 p. m. Nourishment.
4.00 p. m. On duty.
6.00 p. m. Nurse baby.
Rest of day. Same as in "A."

D. Dish washers and dish wipers:

7.00 a. m. On duty.
9.30 a. m. Bathe babies (as in "A").
9.50 a. m. Nurse babies (as in "A").
10.30 a. m. Free for rest or recreation.
12.00 noon. Dinner.
12.20 p. m. On duty.
1.50 p. m. Nurse babies.
3.00 p. m. Nourishment.
5.50 p. m. On duty.
6.30 p. m. Nurse babies.
Rest of day. Same as in "A."

Monday.—2.30 p. m.: Glee club. 7.30 p. m.: Home and personal hygiene lectures; cooking and dietetics.
Tuesday.—7.30 p. m.: Big Sisters' evening.
Wednesday.—Open.
Thursday.—Open.
Friday.—7.30–9 p. m.: Sewing class.
Saturday.—Club night.
Sunday.—7.30: Evening service (chapel service each evening).

One afternoon a week small groups were entertained in the homes of friends of the hospital or taken out for rides around the city. At least one party each month was held at the home. A musical program was furnished by the school of music of the State university the first Wednesday of each month during the school year.

As much freedom as was consistent with the standards of the home and the welfare of the patients was permitted in the matters of visitors, visiting hours, and patients going away from the premises for recreation, church, and such necessary business as shopping. For necessary chaperonage the services of volunteers, as well as of older patients who had proved trustworthy, were utilized with advantage.

A hospital library supplied by the city public library was in use.

To prepare the patients for future employment the home had well-planned courses in home making, including sewing, cooking, home hygiene, personal hygiene, and care of babies. Not only were the girls taught to do this work properly but they were given credit for whatever work they did in the hospital by a system of rating. By this plan of rating patients might repay the home for their care by doing a definite amount of work, and they sometimes had a cash credit due them on leaving the department of aftercare, especially patients whose hospital expenses were paid by the father of the child (as is the usual procedure when orders are fixed by court) or by relatives. This is perhaps the most interesting single point in the plans of this home and indeed one of the most significant points in social service in all the institutions visited in the two States. Because it points the way to efficiency in managing a maternity home, because it is an excellent plan for preparing patients for the future during the period of residence in the home (at the same time making for morale and discipline), and because of the great advantages to the patient, the entire rating system as worked out by the superintendent and the director of social service has been included in this report.

The rating system was as follows:

Classification of work

Class A workers: Pantry girl, waitress, diet-kitchen worker, cottage cleaner, office worker.

Class B workers: Dish washer, dish wiper, vegetable cleaner, cleaner of pots and pans, laundry worker.

Value of work

Class A: Thirty-five and one-fourth hours of work a week (4⅜ days of 8 hours each) equals $14 or maintenance (no charge is made for maintenance of babies).

Class B: Forty-four hours of work a week (5½ days of 8 hours each) equals $14 or maintenance.

Overtime work is paid for at 15 cents an hour.

Credit for work

Waitresses work approximately 40¼ hours a week; they receive maintenance and $3 a month.

Diet-kitchen girls work approximately 40¼ hours a week; they receive maintenance and $8 a month.

Cottage cleaners receive maintenance and $5 a month.

Dish washers, dish driers, vegetable cleaners, etc., work approximately 44 hours a week; they receive maintenance.

Office girls work approximately 35¼ hours a week; they receive maintenance.

Pantry girls work approximately 40 hours a week; they receive maintenance.

The hours of laundry work are not long enough to enable girls doing it to receive maintenance for that work alone. Girls who do both laundry work (cottage hours) and linen-room work or sewing receive maintenance.

Girls who do both linen-room work and dormitory-floor cleaning receive maintenance.

One of the duties of the director of social service was to arrange assignments of patients to certain household duties after consultation with other staff members, considering the condition and needs of the patients rather than the needs of the house. The reason for this was that the social-service director had to plan for the patient's later employment, and she wished to be thoroughly conversant with her capabilities, preferences, and defects.

After discharging a patient the home made an effort to retain contact with her for one year if she seemed to need further assistance and supervision in adjusting herself anew to her community. This contact was kept by a definitely worked-out scheme, made possible by the use of volunteer workers, who made friends with the patients while they were in the home and continued these friendships so as to be of real service to the girls afterward.

The members of the board of directors were actively interested in the work of the hospital. Committees of members worked with the staff on such matters as the social-service department, education, recreation, religious services, Big Sister work, adoptions, aftercare, and the general welfare both of married and of unmarried mothers. With the help of these committees courses in preparation for the patients' future employment and in general educational work were worked out. These activities by the board members fostered interest in general community problems, in educational propaganda for social service, and in social legislation. They constituted an important liaison between the community and the actual work within the institution—a function of paramount importance to social agencies and institutions.

Home II

This home had been established by a religious group. At the time of the study it was located in a residential part of the city, but a new building was in process of construction in a suburb. The place was very homelike, and it was pervaded by a fine spirit. It was comfortably furnished, and its appearance indicated general use as though by a family.

Though the superintendent was not highly trained, she was a person of good fundamental education, a practical nurse. Her only preparation for this work was years of service in church work, but she had certain valuable qualifications. She was a kind, motherly woman, with intelligence, and she seemed to have the ability to understand the girls and to win their confidence. She gave excellent cooperation to the medical staff. She needed more assistance, for she had the entire care of the patients in the main building, a practical nurse being in charge of the isolation cottage.

The medical practice was standardized by the faculty of the State university. All applicants were isolated until a physical examination had been made by the attending physician. Those found to have syphilis were transferred elsewhere. There was a cottage for the segregation of gonorrheal patients. In addition to the usual physical and obstetrical examinations, nose and throat cultures were made, and no patient was admitted to the general dining room unless the results of that examination were known to be favorable. Vaccination against smallpox had been made obligatory by the home, although it was not a requirement of the State law. No dental service was arranged for unless the need was imperative, as the task of taking the patients to a dental clinic would have been impossible for the small staff. The temperature of all patients with gonorrhea was noted daily as a part of the routine observation in order to detect low-grade infections, both before and after confinement. A study of the morbidity after confinement of these infected patients was in progress. A physical record of the patients that lived under observation in the cottage was kept fairly well. It was written in narrative form by the practical nurse in charge. All obstetrical and laboratory records were kept at the hospital.

There was no delivery room in the home; many of the patients went to the State university hospital for confinement and a few to other hospitals.

Breast feeding was not always supervised because of the lack of trained help. A young woman was seen feeding a 5-weeks-old baby from a bottle, and she said that no measures had been taken to influence her to try to continue breast feeding. The diet of the home was rated as "possibly inadequate" for both pregnancy and lactation—too little milk was used. The nursing mothers were given two extra lunches daily.

Preparation for future employment consisted of training in household wrok and sewing. Occasionally a girl was given opportunity to prepare for some other kind of work.

The social records were compiled by a clergyman, a member of the board, from information which he obtained in part from the girls. This procedure was inadvisable, and some of the information recorded was unnecessary for the purpose of these records.

Originally the home did boarding and placing out of babies. In recent years this work had been transferred to a placing agency having high standards.

Home III

This large institution was housed in a new building combining a maternity home and a maternity hospital. It was well equipped for medical and surgical care, but it seemed to lack firm, efficient management and orderly routine. The atmosphere in the home was difficult to interpret. The patients seemed to be repressed, though there was evidence of kindness and of a sympathetic relation between staff members and their charges.

The work was begun 50 years ago by a group of local women engaged in rescue and missionary efforts. At first various types of women had been accepted for moral rehabilitation. Later, work with all these except unmarried mothers was discontinued, chiefly because of the opening of State reformatories for girls and women.

The home had facilities for the treatment of patients with venereal disease, including an isolation ward of 10 beds, with adequate toilets, washbowls, and bathtubs and a shower bath. However, the management preferred not to accept such patients and did not inform social agencies that it would accept them.

The arrangements for receiving new patients were good. Each applicant was shown into a reception room from which opened a small apartment where she prepared for physical examination. This apartment included also an examining room with a table, a medicine closet, and the physician's laboratory equipment. The patient was kept for a few nights in a single bedroom with toilet and bath.

The house physician, a young woman, gave each patient a thorough physical and obstetrical examination, of which a record was kept. The technique of delivery was very good. The physician and a graduate nurse were prepared as for a surgical operation. A student nurse was in attendance also. If a laparotomy was necessary the patient was taken to a general hospital.

The diet kitchen where the babies' food was prepared seemed to be well equipped and well conducted. Instruction of the mothers in breast feeding was given according to the best practice. Every baby was weighed before and after the daytime feedings, and records were kept of the weights. These records, however, were not used to make a general study of conditions. Breast feeding was supervised, and dissimulation was practically impossible.

The diet was rated as "probably adequate" for pregnancy and "possibly inadequate" for lactation. Butter substitute was used; and although milk was available in the diet, it was said that not much was used. The proportion of mothers who nursed their babies adequately could not be obtained. The babies slept or played on a well-screened sunny porch on the second floor.

Certain excellent arrangements prevailed for teaching the girls, giving them both fundamental education and special preparation for future employment.

The board of managers were not entirely in sympathy with the policies of the State board of control. The records were not well kept. Evidences were not lacking of the home's desire to find babies for good foster homes, rather than to keep mothers and babies together.

Home IV

This home had been opened by a religious group to provide care for various types of women—delinquents and others needing care—many of whom were committed to the home by courts. With the opening of two State reformatories—one for girls and one for women—the courts discontinued sending delinquents to private institutions, so that the women in this home began to be limited practically to unmarried mothers, though occasionally other women were accepted.

The building was plain, comfortably furnished, and immaculately clean and sanitary, and the atmosphere in the home was one of content and freedom. The superintendent was friendly and kind, and she seemed to have the respect and affection of the girls.

The medical assistance was good, and whether a woman was the private patient of the house physician or was a recipient of the free prenatal service of a hospital she was well cared for.

Applicants were supposed to bring a certificate of freedom from venereal infections, but each one was examined at the home whether she had a certificate or not. No applicant with venereal disease was admitted; but since there was no isolation or segregation of applicants while waiting, it is conceivable that patients with such infections might remain in the house for a few days. An effort was made, however, to have the examination on the day of the patient's arrival. Syphilitic or gonorrheal patients were transferred elsewhere for treatment. An obstetrical examination was made as soon as the hospital for confinement was decided upon, and thereafter the prenatal care was directed by that hospital. There was no delivery room in the home. The home cooperated with the hospitals in every way, and good results were obtained. The superintendent accompanied each patient to the hospital for delivery and brought her back after the period of hospital care.

A nurse was engaged specially to care for the babies, and she cooperated well with the physicians. The nurse, the babies, and the nursing mothers all slept on the same floor, but the babies were not nursed after 10 p. m. Some one was in charge of the babies all the time.

Special service was rendered by dentists' assistants, young women who came to the home to clean the teeth of the patients and advise them about dental care. All necessary dental work was done at the city hospital, and its prenatal clinic was vigilant about dental caries and sinus infections.

The food seemed good and bountiful, though, as judged from the menus furnished, it was rated as "probably adequate." The home had a garden plot, chickens, and two cows. Cottage cheese and cream dressings were in common use, and the cook was skilled in preparing egg and milk dishes.

The matron assigned a variety of duties to the patients. A fair degree of freedom was given them in the matter of going out alone to church and on various errands.

Though licensed only as a maternity hospital the home was permitted by the State board of control to care for a few children temporarily, so as to assist mothers with their plans. These children might be boarded or cared for free of charge. It was noted that this group was not limited to the children of mothers cared for in the home; also that the number allowed had been exceeded. These facts show some of the difficulties in regulating maternity homes and holding them to their own line of work.

This home had the confidence of local agencies and of the State board of control because of the frankness and the cooperative spirit of the management, though the workers recognized its limitations.

Home V

This home was of a type of commercial institution particularly dangerous in any community. The proprietor, who was also superintendent, was a woman of very limited education, a practical nurse who practiced midwifery. She advertised in a daily paper both maternity and infant care. Her licenses were for a maternity hospital and for a boarding home for children.

The house was a frame dwelling; therefore, by requirement of the State board of control, all the children were kept on the first floor so that they could be carried out easily in case of fire. The place was comfortably furnished, and when visited was clean and in order though quite crowded. The crowding increased the hazard from fire. The kitchen was dark and the bathrooms and plumbing were old-fashioned.

The house had no facilities for segregation, though patients with gonorrhea were received and treated. It was claimed that patients with syphilis were excluded, but owing to the fact that routine examinations were not made it was conceivable that these patients might have entered. No records were available of prenatal or obstetrical examinations, but from the superintendent's verbal account of the work it could be assumed that obstetrical examinations were made. For example, she said that "a woman was taken to the hospital for

Cersarean section." It seemed that the visiting physician who attended deliveries arranged for emergency work to be done outside the home.

The diet was rated as "possibly inadequate" for both pregnancy and lactation. The superintendent claimed to furnish food bountifully, but there was no special effort to have the patients eat the most suitable food. Milk was not much used. Upon being qestioned the superintendent said, "The girls can have milk if there is any left over."

No dental service was furnished, nor any special attendance in case of low-grade infections.

The superintendent was judged to be cooperative with the physician in attendance, but the medical standards of the home were not of the highest.

The maternity register was in bad condition. The record of the disposition of the baby was omitted in every case; various dates were also omitted. Certain births which had been recorded as legitimate were found to be illegitimate. About half the patients were said to be married; but it seems improbable that married women living in the vicinity would leave their homes and come to this place weeks in advance of delivery with hospital facilities available elsewhere in the city. Some of these patients had not consulted a physician, and the proprietor of the home called one for the delivery from a small group who used her home.

The owner of this hospital seemed to be a kind, well-meaning, but ignorant woman. Only one local social worker expressed confidence in her.

Home VI

This was the most recently organized of all the institutions studied in Minnesota. Primarily it was for the care and training of delinquent girls who might be helped by a certain amount of freedom rather than by the restraint of a reformatory. The addition of work for unmarried mothers had been incidental to the other work and had been made because of unsatisfactory conditions long existing in the other two maternity homes in the city.

All the staff members met were women of culture and good preparation for their work, and they were zealous for the best results. The austerity of some of the arrangements, especially of the hall in which the patients had their meals, ap peared unattractive; but there was a very good spirit, and the girls looked happy and healthy. There seemed to be more unity in the interests of the group than in some homes where the appointments were more elaborate.

The medical work was carefully done, and records of all examinations were on file at the hospital, which cooperated understandingly with the staff of the home. The home had made a complete report to the State board of control of health work done in the previous year (dental services, major and minor surgical operations, glasses and braces fitted, and venereal-disease treatment given) and of the results of intelligence tests. The staff closely followed physici ans' directions.

The cooperating hospital gave unusual service to this home in keeping the patients for an indefinite time, allowing them to remain throughout any emergencies such as ophthalmia in an infant or evidences of any infection in the mother. If any condition arose after her return to the home that necessitated bedside care she might reenter the hospital, and if her baby was breast fed it might go with her and be cared for in the pediatric ward.

The diet rating was "probably inadequate" for pregnancy and "possibly inadequate" for lactation. There was reason to believe, however, that the sample menus which the staff furnished for this rating did not represent the diet to the best advantage, as the gardens, cows, chickens, and rabbit hutch all contributed; and it was found that some simple but important things such as cottage cheese and skimmed milk had not been considered worth mentioning in the menus, although they were in rather common use.

The training of patients for future employment was varied and efficient and showed utilization of all available resources. Courses in home nursing were provided by the Red Cross; teachers were procured from the extension division of the State universities. A 13-year-old girl (not a maternity case) was attending public school at the time of the study; and four girls, one a mother whose child had died, were taking business courses at the expense of the home.

Ample provision was made for outdoor life, both work and recreation. About half the proceeds from certain work done by the girls was used to finance recreational activities; the other half was kept by those who did the work.

There was no dining room, a large hall being used in lieu of one. The living room, opening from this hall, might better have been used temporarily until a suitable dining room was added. This living room and the sun parlor were simply but attractively furnished. Good pictures, books, magazines, and other similar touches added greatly to the good impression.

The home was overcrowded; it seemed that in their zeal to render service the staff had taken in too large a number of persons.

Home VII

This institution was not only a maternity home but also a place of temporary care for dependent children under 2 years of age. It was of more recent development than most of the homes studied, as it was founded less than 20 years ago. At the time of study the superintendent had been in charge less than two years, and great improvement had been made in that time.

All admissions to this home were made through a certain social agency which was controlled by a religious denomination. A preliminary social investigation was made by this agency to help to decide whether the applicant should be admitted. The agency gave also a physical examination so as to exclude any applicant with venereal disease. The county child-welfare board assumed complete responsibility for all maternity cases after admission to the home.

The house was well equipped and exceptionally well kept. Only a few defects were noticed. One of these was the crowded condition of the dormitory where both waiting and nursing mothers slept. Another was the lack of a living room for the girls; it was expected that one would be supplied before long. The dining room was most attractive, and it was used temporarily as a living room.

Medical care was given to maternity patients at various clinics, and the home carefully carried out all directions given at the clinics. Dental work was arranged for if the clinic physicians considered it necessary. Obstetrical examinations were made at the clinics, but specific information on these was not sent to the home, and it was not known whether they were thorough.

At the onset of labor each patient was sent to a hospital for delivery. Several hospitals were used, and a patient might be sent to one that did not have the record of her prenatal care. At one hospital it was said that pelvimetry was done "if there was time before delivery." Patients returned to the home soon after delivery, and there was no provision for bedside care in the home. The superintendent was very particular about the health and comfort of the patients, and if any of them felt ill they were sent to a clinic.

The diet was good, being rated as "probably adequate" for both pregnancy and lactation. The girls might have all they wanted to eat, including lunches between meals. The waitresses were instructed to notice timid ones at meals to see whether they would like second helpings.

The children were well cared for and had the services of a pediatrist. Excellent isolation facilities were provided in case of infection. Trained assistants carried out the directions of the physicians.

The group of dependent children was entirely under supervision of the social agency previously mentioned. Every child of illegitimate birth who was retained in the institution after his mother had left remained under supervision of the county child-welfare board unless the guardianship was taken from the mother, in which case the child was committed to the agency for placement.

The social atmosphere of the home was particularly good and the superintendent was sympathetic. The maternity patients were given as much freedom as was practicable, the home's nurses and volunteer workers acting as chaperons when necessary. Training for employment was practically limited to household work, sewing, and the care of the babies; a few girls received training in diet-kitchen work.

The home was constantly occupied to capacity, receiving girls from all parts of the State. The records were well kept.

Home VIII

This home was a well-ordered place housed in an attractive building with large grounds. It had a good, efficient matron and a particularly congenial staff. Every department seemed busy and happy. It was an outgrowth of missionary work by a local group of men and women, and it was one of the oldest efforts of its type in the State. In the early years of the work various types of women needing

care were accepted, but at the time of the study the only ones cared for were unmarried mothers. The home was licensed only as a maternity hospital.

The attending physician, a woman, called twice weekly and not only gave good prenatal and obstetrical care but also instructed the patients in personal hygiene and the care of their babies. She received good cooperation from the rest of the staff. A small laboratory equipment was used at the home for urinalyses, and the city laboratory and the State university laboratories were also available.

Each applicant for admission to the home was detained in isolation until a physical examination was made, as no patient with a constitutional disease or an acute infection was kept. The facilities for isolation and segregation were good.

The diet kitchen, the babies' bathroom, a delivery room with bath, and a two-bed ward were on one side of a corridor, and on the other side a single-bed room, an examination room which had equipment for special cases, and a labor room. The delivery suite was especially well arranged and safeguarded.

The diet was rated as "probably inadequate" for pregnancy and as "possibly inadequate" for lactation. Breast feeding was supervised and the babies were well nourished. They were kept in a nursery under the care of a trained nurse, and the mothers went there to nurse the babies and sat in low rocking chairs by the babies' beds.

The superintendent was a very businesslike person. The home at first gave the impression that certain human interests were sacrificed to business efficiency; but this impression was dissipated by observation of the girls at work, at meals, etc. No girl was permitted to leave the home unaccompanied for any purpose. Groups of girls were accompanied to church, on walks, and on little outings. There were no other outside activities. Preparation for future employment was limited to training in household work.

Records were very well kept. For years the management had followed the policy of keeping mothers and babies together for the moral effect on the mother; for this reason the records showed, generally, that mother and baby left the home together. However, these records showed a number of separation plans made while in the home, and this frankness of the home is to be commended. The superintendent would not permit any of her staff access to records; nor would she allow discussion of the "girls' stories" with them. She had fixed ideas as to confidential relations with her charges. The home had not been running to capacity—a matter of concern to the management.

The idea of religious reformation was uppermost. The superintendent was making an earnest effort to continue contact with as many girls as possible after discharge. The cooperation of the county child-welfare board rendered this contact entirely practicable.

Home IX

This institution, which gave both maternity-home and maternity-hospital care, had been built by a philanthropist, and it had every facility for medical care and treatment which modern scientific methods demand. A suite of rooms was designed especially for the use of applicants for admission, and segregation might be maintained there for an indefinite period. On each floor was a solarium and a bathroom. Everything was exquisitely clean. The nursery was especially attractive.

All the medical care was given within the home and the visiting physicians kept good records of it. No patient was received unless she had been certified by the State board of health as free from venereal disease. If a patient had a vaginal discharge but had been pronounced free from gonorrhea she might remain in the home under observation, and the nurse gave her treatment according to the physician's directions. Any baby with ophthalmia was separated from the others, even though he had been examined and the infection found to be not of venereal origin. After delivery patients received bedside care in large, airy wards on sun porches. They were not expected to assume any duties until four weeks after confinement.

The diets were too frugal. They seemed entirely inadequate to mantain a woman properly, and they surely did not contain sufficient calcium, phosphorus, and vitamins for women in pregnancy and lactation.

The home had a fine spirit of service and cooperation, although it had certain limitations. It was licensed only as a maternity hospital, but the State board of control permitted it to keep a small number of children so as to assist with their

plans mothers who had been cared for in the home. The home wished to continue contact with the mothers for moral influence and therefore encouraged them to return for visits. At the time of the study about 100 girls constituted the group of discharged cases who were still in contact with the home. This seemed a small number after the home's years of work, during which approximately 100 girls were received annually, but frequent changes in the personnel of the staff might account for it. The only training given in the home was in housework and sewing. Some art needlework was taught, and the work was sold, the proceeds going to the home. It would seem that at least part of the money should have been kept by the workers or used for their direct benefit.

The superintendent approved marriage of these mothers "for the child's name," even with divorce in mind as a later solution. This is in contrast to the attitude of most social workers, who would give approval and encouragement only to those marriages which are mutually desired and which give promise of some permanency.

Social records were well kept.

CASE STORIES

In one home an Indian girl was met who was mature in appearance, much older than her age, 19. One afternoon while the Children's Bureau representatives were engaged in the home this girl brought in tea. She was dull and phlegmatic until her child, a beautiful baby, was mentioned. Immediately she showed animation.

This girl had been met by a worker of this home in missionary work on an Indian reservation. Her parents were in almost destitute circumstances and she had no prospect of suitable care at the time of the birth of her coming child. At the time of the bureau study she had been in the maternity home for some months and she had reacted well to the efforts made to assist her. Besides being given instruction in English and arithmetic by a qualified teacher she was being taught household work. The assignments of work were graded intelligently and the training was thorough. She was also taking complete care of her child, having been taught this first of all. Through the joint effort of the home and the county child-welfare board the father of the baby had been placed under court order for its support.

The plan for the future was not quite decided. The patient's parents wished her to return to the reservation with the baby, but she preferred to take a domestic position where she could keep him with her and could make use of what she had been taught in the home.

A capable, robust girl of 18, approaching delivery, was observed doing some out-of-doors work at one home. A child, near by in a carriage, began to cry, and the girl hurried to soothe him. Her eagerness and gentleness in giving the child attention were noticeable.

This patient had been referred to the home through her church, and she was being provided for by her parents. The plans for her future had been left chiefly to the county child-welfare board, which was endeavoring to reach the man responsible for her condition. The girl was doing light housework and sewing. She had been promised a place in the domestic-science class after the birth of her baby, and she was looking forward to it.

In one home a gentle, timid girl of 17 was seen. She had returned to the home from the hospital with her baby a few days before and had not yet been allowed to do any work. Her first assignment would be to give her baby his morning bath, and later she would participate in the household duties.

This patient was in the third year of high school when she became pregnant, and she had confided in her mother as soon as she knew it. The young man deserted her, marrying another girl, but his parents were sympathetic and had promised to arrange a settlement for the baby's support. This was to be done as soon as the girl was strong enough for the necessary interviews with attorneys and other details of the business. Her parents would then take her and the baby home to their farm.

During the study of one home (a commercial home) a woman who appeared to be about 35 years old was seen. She was a pay patient in the home and therefore did not assist with the work of the house. This patient had been in the home for more than two weeks and her baby had not yet been born. The proprietor of the home had engaged for this patient a local physician who frequently attended her patients.

The patient's story as told to the owner of the home was that she was a married woman and had left her husband and two children at their home in another city to be near this physician. Her husband had not communicated with her. The patient appeared to have ample funds to meet all expenses, and she might have entered an excellent hospital in this city or one much nearer to her home.

An attractive, capable-looking girl about 20 years old was on duty as door maid in a maternity home, and in the course of a day's work she was seen frequently. This patient gave her baby attention, including the morning bath, and nursed him at regular intervals but had no further contact with him. He was 2 months old, and the home had a policy of deferring the plans for babies until the third and last month of the stay of the mothers.

This girl had been reared by an older sister, her mother having died when she was a small child. The sister and four married brothers were all insisting that she place her baby in a foster home for legal adoption and return to her former life with them. This the young mother positively refused to do. She was hoping to be permitted to enter a training class for nursemaids which the home provided, because that would enable her to live with the baby during the months of the course and then to take employment which would assure her wages sufficient to provide adequately for the child in a boarding home.

A case indicating the injustice of planning for the placement of children without covering all possible resources for providing care with relatives was noted in one home. It was the case of a girl less than 18 years old, who looked several years older and who was capable, dependable, and handsome. This girl was still nursing her 3-months-old baby, though arrangements were being made by her parents and the home for placing him in a foster home for legal adoption.

While in high school this girl had become pregnant. Since business reasons made it convenient for the family to move they came into this State from an adjoining one. The young mother's stepfather (her mother had been divorced and had remarried when the girl was a small child) had visited the home of the young man responsible for her pregnancy, had seen him and his parents, and had learned that he was anxious to marry the girl before the baby's birth but did not know her address since her family had moved. His parents were anxious that their son rectify his injustice to the girl and the coming child by marriage, and they were willing to give the young couple a start in their home until they could make their own home.

The girl was told nothing of all this. Her mother felt that the young man was socially inferior, and she wanted her daughter to complete high school and enter college; so the girl knew nothing of the opportunity to give her child a legal status nor of the young man's wish to make what recompense he could to her. She stated to the bureau worker in a burst of confidence that she was almost insane with fear of being found out, because her family had woven a fabrication of lies to conceal her whereabouts; also that she loved her baby and, if she would follow her own inclination, would "walk out with him and work to support him"; but she felt a deep obligation to her stepfather, who had generously supported her almost all her life, and he wanted her to please her mother.

Fortunately, this case had to be approved by the county child-welfare board before the baby could be placed. Otherwise, there would have been no chance for this young couple to marry and give their baby the protection due him and their affection and care.

The girl's family and the maternity home had conspired to permit a child to be born out of wedlock when they might have been instrumental in giving him the advantage of legal birth.

MATERNITY HOMES IN PENNSYLVANIA

LEGAL PROVISIONS

The terms maternity home and maternity hospital were not defined in the Pennsylvania law until the enactment of the administrative code by the legislature in 1923. In this code they are defined as any house, home, or place in which, within a period of six months, any person receives for care or treatment, during pregnancy or during or immediately after parturition, more than one woman, except women related to such person by blood or marriage within the second degree. This code further provides that the department of welfare shall have supervision over all maternity homes and hospitals within the State. Until the enactment of this code there was no centralized registration of maternity homes except those which received State aid through the department of welfare.

At the time of the study statutory provision for licensing all maternity homes and hospitals and child-caring institutions and agencies had not yet been made in Pennsylvania. However, the act which created the department of public welfare in 1921[1] gave to that department certain supervisory powers over child-caring institutions and agencies, and maternity homes were considered as coming within this category. This department, then less than two years in existence, was operating under the act of 1921 during the time when the Pennsylvania institutions were visited by Children's Bureau agents. In 1893 an act had been passed by the legislature providing for permissive licensing of maternity homes and hospitals by local health boards. Homes and hospitals licensed under this law were to be subject to regulation and inspection by the local health boards, and their licenses might be revoked by these boards. The license was to be renewable every two years at a cost of $5. Record books were to be kept by the proprietor or superintendent showing the name, the address, the date of admission, and the date of delivery of each patient and the date of removal of each child and the address of the place to which such child had been removed. The passing of this statute indicated a realization of the problem of illegitimacy in the work of maternity homes and hospitals and of the fact that special care and protection should be given children born in such institutions. However, the local health boards' lack of facilities for investigating applications and for supervising licensed homes and the fact that an incorporated institution could be operated without a license greatly lessened the effectiveness of this law.

[1] Acts of the General Assembly, 1921, ch. 425. In 1923 the title of this department was changed to department of welfare, and power to supervise maternity homes was specifically granted. A law passed since the study was completed (Acts of 1925, ch. 155) provides for compulsory licensing and inspection of all boarding houses for children except institutions duly incorporated for that purpose.

ORIGIN AND DEVELOPMENT

The 24 homes studied were located in eight counties. Three were established more than half a century ago and one more than 40 years ago. Ten homes were opened at various times from 1890 to 1897, more than half of them through the efforts of Mr. Charles Crittenton. The other 10 were established since 1890.

Twenty were incorporated and hence were not locally licensed, one was maintained by an incorporated society, two were licensed, and one was neither incorporated nor licensed.

Thirteen of the 24 homes were established through religious motives. Two were established for the purpose of providing medical care for women, and four to provide medical care and social protection for unmarried pregnant women. Two of the 24 homes were owned and managed by individuals for personal profit only. What purpose actuated the founders of one home was not clear; although this home had been founded probably with charitable intent, its policy at the time of the study seemed questionable. Two homes were originally child-caring institutions.

The original policies had been modified in some of the institutions; six which at first admitted indiscriminately all types of immoral or needy women had narrowed this policy and were concentrating their efforts on unmarried mothers, and a few of these homes admitted only unmarried women pregnant for the first time. In contrast to this policy, five of the 24 homes studied accepted both unmarried mothers and other girls needing care. The youngest girl in any of the homes at the time of the study was about 12 years of age. One home had greatly departed from its early policy by adding a department for the care of aged women. Eleven homes had made no change in their early policies.

At the time of the study five of the homes accepted practically all types of women needing moral regeneration. Five had departments of child care and accepted children for temporary care. Two which began as child-caring institutions later admitted pregnant women, adding facilities for their treatment.

The combinations of service given by the Pennsylvania homes at the time of the study were varied, their programs showing from one to four types of service. Two homes restricted their work to one service—that of the maternity home—providing care for women before and after confinement. Five homes did two kinds of work, as follows: One provided maternity-home and hospital care; two gave maternity-home care and accepted children for care; one gave maternity-home care and had a department for care of aged women; one gave maternity-home care and accepted various other types of women, such as those who were unemployed or who for some other reason needed the temporary shelter of the home. Ten homes did three kinds of work: Three of them gave maternity-home, hospital, and child care; three gave maternity-home care and child care and did child placing; one gave maternity-home care and hospital care and did child placing; one gave maternity-home care and child care and accepted women needing temporary shelter; two provided maternity-home care and child care and accepted delinquent girls. Seven homes did four types of work; six of these gave maternity-

home, hospital, and child care and did child placing; and one gave maternity-home care, hospital care, and child care and accepted delinquent girls.[2]

The women who were not maternity cases—such as homeless and unemployed women—were few in number in most homes, and the tendency was to discontinue receiving them. In some homes the number of babies cared for was small, and little placing in foster homes by these homes was done. Some homes were tending toward the policy of referring problems of child placing to children's agencies, and some had given up child placing. The most varied combinations of service were found in some of the largest institutions, where the staffs were able to give fairly satisfactory supervision to the different types of work, but several combinations were also found in certain small institutions having only two workers. In an institution run by one woman with no assistants three types of service were rendered—maternity-home care, child care, and child placing. The commercial homes visited were among those doing child placing. One maternity home which did child caring and child placing had as inmates a small group of chronic invalids of varying ages and types. Some of the homes having young dependent and delinquent girls and other types as well, provided no segregation for the different types. Although the workers in some of the homes showed a willingness to admit practically any person to whom they might extend the facilities of their institution, the admission of other than maternity cases was sometimes the result of the appeal of other agencies for help. Instances were found of maternity homes accepting schoolgirls and homeless and unemployed women at the solicitation of courts and private agencies.

CAPACITY AND POPULATION

The total number of individuals cared for during 1922 could be ascertained with some degree of accuracy for 22 homes, but the condition of the records of two precluded the possibility of using their figures at all. The records of 22 institutions during the year showed that 1,573 expectant mothers, 358 mothers with babies, and 1,389 other inmates, including very young children, older girls, aged women, and women who were chronic invalids, were cared for in these institutions.

The total population of all the homes when visited was 464 women and 787 children. At this time the maternity hospitals in the State were crowded to capacity, but the maternity homes were not. These conditions were more marked in some institutions than in others.

The capacity of 23[3] institutions varied from 6 women and 6 children to 76 women and 375 children (children of the maternity patients and those in the institution's child-caring department).

The 23 homes had an aggregate capacity for 599 women—exclusive of staff members or other employees—and for 1,000 children.

---

[2] In the foregoing classification child care refers to the care of children without their mothers—either surrendered or committed babies of mothers who were cared for in the home or children accepted from other sources.

[3] In estimating the capacity of the institutions one very large hospital was omitted because of the difficulty in ascertaining the number of beds available for unmarried mothers.

GROUNDS AND BUILDINGS

Of the 24 homes in Pennsylvania which were studied 11 were in suburban districts, 12 in cities, and 1 in a rural section. Nine were located in city blocks with no provision for outdoor life except the rear yards. Three of the city homes, as well as all the homes located outside of the cities, had grounds varying in extent from one-half acre to 13½ acres. Several institutions had attractive grounds, providing healthful and pleasant diversion for the patients and the children. Well-kept lawns, trees, flowering plants, and some provision for outdoor life were almost universal in places where the space permitted.

Almost all the homes were housed in one building. The congregate plan was used entirely in 16 homes (only 1 of these had more than one building), and 8 used a group arrangement which was very helpful in preventing certain difficulties of general congregate grouping. Although most of the homes using the congregate plan were small and the types of patients received were not diversified, there were some in which there was great need for separation of different types of patients.

The buildings were of frame, brick, or stone construction and were from three to four stories in height. None of them was fireproof, although many were equipped with fire escapes. Two had a separate building used as an infirmary or a hospital. All but two were in good condition. Only three were built for the purpose for which they were used.

Most of the homes were lighted by electricity; a few by gas. All but one used coal or gas furnaces, and some also used grates or electric heaters. It was noted that several had gas stoves with no vents for noxious gases. One home was heated by grates, gas and kerosene stoves, and a coal range in the kitchen.

As a rule the kitchens and the dining rooms were on the first floor and were adequately lighted and screened. The equipment was very good in some of these dining rooms, ordinary in others, and in three might be described as undesirable. The patients served the meals in all the homes, and they had the same food as the staff members except in four homes; in these the staff members had a separate dining room. In one home the staff had a separate dining room but the same food.

One home had all single rooms with single beds. Six had no single rooms; two had double beds in single rooms and in dormitories; one had two or three single beds in each room but never permitted more beds no matter how large the room might be; another sometimes had three single beds in each room; and others had from five to nine single beds in dormitories. The space between the beds varied from 1 foot to 4 feet. It was said in all the homes that the windows were opened at night.

Toilet conveniences were provided in every home, and each had bathing facilities, some both tubs and showers. One had a well-equipped indoor swimming pool for children and adults, and another had an outside pool. In some institutions the patients might bathe when they pleased; in others they were required to bathe daily or weekly. All homes provided individual bath towels, and all but one provided individual face towels. It was noted that in order to insure

individual towels for children in one home a clean towel was provided each time a child was washed. Hot and cold water were furnished constantly in all but two homes, where the range fire supplied the heat.

One home had a well and the others obtained water from city supplies. Garbage collection and sewage disposal were under city control, except in two homes where a cesspool and a septic tank were used and the wet garbage was fed to chickens.

Sanitation in general was rated as "good" in all the homes.

ADMINISTRATION

BOARDS

A large majority of the homes, 20 of the 24, were controlled by local boards, 7 of these having cooperative relations with national organizations and 2 with local religious groups. Two were part of a national organization and were under its general direction. Two were commercial enterprises and were not controlled by boards.

Six of the local boards were composed entirely of men, and 10 entirely of women; 4 had mixed membership. Several boards were restricted to persons of a particular religious denomination; and other boards required certain other conditions as to the personnel and as to the territory to be represented.

Most of the boards were self-perpetuating. A group membership elected the members of four boards. No special requirements for membership were noted in seven homes save a denominational membership. Meetings were usually held monthly.

STAFFS

One of the superintendents was a physician; one had a certain amount of medical training; five were graduate nurses; two were college graduates; three had had some high-school work and some professional training as teachers. The others had varying degrees of elementary, high-school, and college work. Three superintendents had had definite social-work training, and several others had had some experience in various kinds of social work. Three had a personality particularly suitable for their work—sympathy and understanding, together with background and education. Most of the others had qualifications which were of value; and it seemed that they would inspire confidence in their charges, nearly all showing kindness and consideration for them. Their institutional experience varied from 2 to 33 years. The majority of them were resourceful; but some seemed to lack initiative, and the two superintendents of the commercial homes were apparently interested only in profits.

Most of the superintendents were allowed a marked degree of freedom by their boards, and some had unlimited freedom. Some met with the boards, one having a vote in the executive committee. Salaries varied from $360 to $2,000 a year, with maintenance, although five superintendents drew no salary, two of these being the proprietors of commercial institutions and three members of religious orders.

In all the homes except one the superintendents had staff assistants—from 1 to 25. In 13 homes the assistants were chosen by the

superintendents, and in the other 10 they were appointed by the board or with its approval.

The institutions having very large staffs were those which had large departments of child care. The educational qualifications of many assistants were limited to elementary-school work; of the assistants listed in 23 homes, only those in 15 homes had more than a common-school education.

A number of the homes had assistants who were trained nurses, particularly homes having large child-caring departments. Four of the homes had resident physicians. Six had dietitians, trained social workers, or other types of persons who had special professional preparation for their work. Six persons were designated as social workers for work outside of the homes—investigation, prosecution of cases to establish paternity, placing and supervision of babies, and raising money for the institution. Two of these six workers had had no preparation for social work. In several of the homes good work was done by the superintendents or other staff members in making investigations and in follow-up work with the mothers. Many of the workers had had years of practical experience in institutional work.

The duties of the assistants were usually assigned by the superintendents, and they consisted in supervising and training the patients and caring for the children. In a number of the homes nurses, graduate and undergraduate, were employed to care for the mothers and babies. In a few instances, however, this was the duty of untrained practical nurses.

The minimum salary reported was $120 per year and the maximum $2,500. This latter salary was unusual, being paid to the director of the social-service department of a large institution.

In all but one home the patients did some or all of the work of the institution; in eight homes they received compensation for this work.

FINANCES

Methods of financing the homes included State appropriations of lump sums, pro rata amounts paid by counties, endowments, contributions of money, food, clothing, and other articles from individuals and groups, appropriations from community chests and federations, payments by patients for care, "surrender fees" for babies, and income from work done by patients.

Twenty-one homes were financed wholly or in part by public appeals or through contributions from local community chests. Nine of these received State aid also, and 12 received city or county funds on a per capita basis. Two were entirely commercial enterprises, and one was supported through its endowment and by money received from pay patients. Finances of some of the homes seemed very involved. The confusion of the financial and personal records indicated great need for standards to protect not only the patients but the communities supporting these homes. The expenditures varied from approximately $1,500 to nearly $80,000. The aggregate amount of State aid for 1922 was reported to be $34,900. Eighteen had accounts audited by professional accountants, 9 of these 18 being State-aided institutions where the books were examined by State auditors.

RATES AND FEES

In 6 homes no accurate data were available on rates and fees paid by patients; 3 homes had no fixed rates or fees; 15 received all or part of the expenses of more than half their patients for the year (485 of 859) either from the patients or from their counties.

Fees collected from patients or their families varied from $100 to $140 each for their care; board from $3 to $35 a week was charged. In some homes the patients did the housework to pay for their hospital care.

INCOME FROM WORK OF PATIENTS

Three homes had an income from the work of patients. In one home patients were permitted to go out to work, usually domestic work by the day, the proceeds being divided equally between the patient and the home. In another home which cared not only for maternity patients but for other cases all the proceeds of the patients' work went to the home; most of the work was laundry work, and the maternity patients were rarely assigned to it. In a third home the profits from art needlework done by the patients were used for recreational purposes for the group of patients.

INCOME FROM "SURRENDER FEES"

The policy of institutions accepting babies of illegitimate birth on payment of a sum of money by their mothers was found to be still in use in four of the maternity homes in Pennsylvania. Two of these were commercial homes and two were under direction of church groups. The babies were accepted in all of them at any time after the end of the period of hospital care. The fees were $50, $165, and $250, and one which could not be exactly determined appeared to be about $165. At the time of the study the institution charging $250 was not accepting many babies on surrender, and those accepted were placed in families with wet nurses. The fee was estimated to cover payment for an adequate period of wet nursing. The institution charging $50 continued its policy of accepting newborn babies, apparently in an earnest belief that this is a truly good plan for the mother and for the baby.

INCOME FROM BOARD PAID FOR BABIES

In some of the homes a somewhat irregular amount of revenue was derived from board paid for babies.

RECORDS AND REPORTS

Just as there has been no central registration of maternity homes in Pennsylvania, so also there has been no standard requirement in the matter of records.[4] As a result of these conditions the records showed great diversity of form and content.

SOCIAL RECORDS

Most of the 24 homes used a record book, in which entries were made of dates of admission, delivery, and discharge; name, birth date, residence, occupation, religion, and nationality of the mother;

[4] A law passed in 1925 requires that footprints or fingerprints be taken of all infants born in hospitals or maternity homes (Laws of 1925, ch. 209).

disposition of the baby; certain facts about the putative father; and the names and addresses of the mother's parents or of some other relative or friend. Very few places sought to ascertain as much information about the putative father as about the mother. These books varied from well-arranged records giving definite and concise information to a few lines giving several items.

In some of the homes the superintendent stated that she could not place such confidential material at the disposal of the Children's Bureau agent or that the study of the records was unnecessary, as she could supply any statistics needed. In 16 homes records of individuals were available and were studied by the Children's Bureau agent. In the other 8 homes the superintendent furnished information. In 1 of these 8 there was no history of the mother except her name and address and the dates of her admission, delivery, and discharge; in another the only record was a sort of log, from which reliable facts could not be obtained; in a third the superintendent stated that the record book was lost; and in the other 5 the agent was permitted to examine the files to ascertain the type of records and the method of keeping them. In 4 of these 5 homes the reports on file were sufficient to supply most of the information desired; but the superintendents preferred giving it themselves to having it procured by the agent directly from the histories; in the fifth a staff member filled out a blank from each record for the year.

MEDICAL RECORDS

Records were kept of the prenatal, obstetrical, and puerperal examinations of patients in all but 4 of the 24 institutions studied in Pennsylvania. Some of these histories were not filed at the homes themselves but in the cooperating hospitals where the patients were taken for confinement care.

Very few records were found giving adequate data on the patient's history, social or medical, indicating the care of the patient and plans for her future. Five places kept chronologically arranged social histories, of which two only were entirely acceptable. Several institutions had summary cards which were well kept, though only minimum information such as a history face sheet contains was found thereon. Occasional instances were noted where records were easily accessible to patients. In one home the superintendent was on the second floor most of the day, while patients, unsupervised for part of the time, were on the first floor, where case histories were in an unlocked file. This superintendent remarked that she noticed evidences of the records "having been tampered with by the girls."

Only 8 of the 24 homes compiled reports. Four of these published the report annually, 1 biennially, and 1 occasionally; 1 issued a typewritten annual report, and 1 issued a monthly bulletin.

ADMISSION OF PATIENTS

SOURCE

In all the homes studied patients were admitted on their own application or on that of friends or relatives or at the request of public and private agencies. In six homes prospective mothers were received on commitment from juvenile, municipal, and county courts. Children were received on commitment in 10 homes. The court

usually retained jurisdiction in these cases since the commitments were only temporary. The two commercial homes advertised in the newspapers and circularized physicians.

Social investigations of the patients before admission or after were made by a qualified staff worker or a standard social agency for only six homes. In 10 homes there was no attempt to investigate the patient's history, and in the rest an interview by the superintendent or a letter of inquiry was the only effort made in this direction. A few superintendents thought that any investigation would violate the confidence of the patient. Only 8 of the 24 homes used the social-service exchange to identify cases.

LIMITATIONS

Race.

Eight homes limited their intake to white women. Two were homes for colored women, and they rarely had any other patients. The other 14 accepted both white and colored women, and two had separate dining and sleeping provision for the two races.

Religion.

No religious lines were drawn in any institution, although in most homes all patients who were able to do so were expected to attend religious services in the home. For this reason one superintendent endeavored to take only girls of the same faith as that of the religious group operating the institution.

Age.

No homes had fixed minimum or maximum ages for maternity patients nor for the other types of women admitted. Most homes caring for children had a limitation as to the ages of those to be admitted. The maximum age varied from 2 to 6 years. In a few homes dependent, "problem," and delinquent girls were admitted as young as 12 years. The preference of the management of most homes seemed to be the young woman, unmarried, who was for the first time pregnant or a mother, as she was believed to be the most hopeful type for reconstructive effort.

Patients in any stage of pregnancy were admitted to all the homes; one home preferred them to enter as early as possible and two did not really wish them to enter before the sixth month.

Residence.

All the homes accepted patients from throughout the State, though several gave preference to those living in the vicinity of the home. Seventeen accepted without restriction patients from other States. A few endeavored to return girls to their own localities, within the State, by transferring them to other institutions.

Marital status.

Although the unmarried mothers constituted the major proportion of patients in all the institutions visited except the large hospitals, married women were accepted when the services of the home could help them over some trying period. Only one home preferred not to accept any married women. These women were never required to stay through a fixed period of time, as the unmarried mothers usually were, and little was done for them except to give them physical care.

Previous pregnancies.

Six homes refused to care for unmarried women during more than one confinement, some even limiting their care still further by refusing to admit an unmarried woman pregnant after the first time whether they had cared for her previously or not. Eighteen homes accepted women in pregnancies other than the first one. Eleven of these limited acceptance of such patients to those who had not been in their institutions before. One home was willing to receive the same woman in a later pregnancy unless there happened to be in the home a patient who might know the earlier circumstances.

Mental defectives.

All the homes except two admitted mentally defective girls, unless their mental condition was such as to create difficult problems in their care. In several homes women were noticed, undoubtedly mentally defective, who had remained in the institutions for a period of years. In one home a woman had remained 18 years. Some superintendents stated that they took these cases only in emergencies or to accommodate social agencies. They were not segregated.

Communicable diseases.

Eleven homes accepted patients having communicable diseases; two of these did not exclude cases of any such disease, and nine excluded all cases of communicable disease except syphilis and gonorrhea. Of these nine two accepted syphilitic cases, one accepted cases of gonorrhea, and six accepted both. It was claimed in 10 homes that physical examination and a certificate of freedom from communicable disease were required for admission. Usually the examinations were made by a private physician—sometimes by order of court, if the patient was committed by the court. These requirements were not inflexible except in three homes.

Four homes did not receive patients with syphilis and were vigilant about observing this rule. Eight homes claimed that they did not accept such cases, but on one pretext or another patients with syphilis had entered, sometimes without the knowledge of the staff, as the medical examinations on entrance were too cursory to detect all such cases. Twelve accepted syphilitic patients and treated them in the home, the municipal hospital, or a shelter prepared to receive them or had them treated in the State clinic for venereal diseases until the disease was noninfectious. Most of the homes that took this precaution were in the eastern part of the State.

Seven homes rigidly maintained a quarantine against patients with gonorrhea. In six homes it was claimed that patients with gonorrhea were excluded, but the examination of patients on entrance was so superficial that the statement about exclusion of these cases seemed questionable. Eleven homes received and treated patients with this disease, keeping them in careful isolation. The 13 homes which did not treat such patients transferred them to a municipal hospital or shelter for treatment until the disease was noninfectious.

In every home any patient suspected of having an infectious disease other than venereal disease was isolated until a diagnosis was made and the case finally disposed of by order of the attending physician or the local health board.

DIETS

Menus were obtained from all the homes except three, and the diets were rated according to the plan shown on page 5. The diet situation was similar to that in Minnesota. More milk should have been used—as a beverage and in cooking—and more vegetables, eggs, fruit, and whole-grain cereals. The diets were rated as follows:

	For pregnancy	For lactation
Adequate	0	0
Probably adequate	1	7
Possibly adequate	13	9
Probably inadequate	7	5
Undetermined	3	3

All milk was Pasteurized, and its analysis and the testing of the cows for tuberculosis were supervised by the local health authorities. No institution owned cows at the time of the study; one had recently been obliged to get rid of them, as they had been condemned as a nuisance because of the flies they drew.

PRENATAL CARE

Physical examinations were given by all the homes. If the patient was not examined on entrance there might be a delay of a few days until she could be taken to a prenatal clinic or until a visiting physician could be called. Fourteen homes detained patients in isolation until the first examination had been made; one was not very particular about this precaution; and nine made no pretense of protecting the patients already in the home from possible infection.

The examination given was fairly complete; it included pelvic measurements in 23 homes, urinalysis and blood-pressure reckonings in all, routine Wassermann blood examination in 11, and Wassermann tests of the placental blood in 6. This was an indication of the effort made to insure treatment of patients with syphilis.

Seven homes were careless about taking a routine vaginal smear, with the result that a patient with gonorrhea might be given the freedom of the home and other patients might be exposed to this disease. Besides the patient with gonorrhea might thus remain untreated, not only to the harm of herself but also of her child at birth. Seventeen homes were careful about this procedure, reflecting credit upon their medical advisers.

In one home it was a routine procedure to give each patient a Schick test and, if the result was positive, to immunize the patient against diphtheria with toxin-antitoxin injections. It was also the regular practice to vaccinate against smallpox each patient on entrance.

Five institutions had fully equipped laboratories and three others had the use of the laboratories of private physicians. The remainder were dependent upon the public laboratories of the State, borough, or city health departments.

The superintendents said that the physicians gave advice and recommendations for the care and treatment of each patient individually.

In three homes definite rest periods for pregnant women were provided; in three others most of the afternoon was free for reading, sewing, or other personal activities; and in another all pregnant women or nursing mothers were instructed to report any illness or indisposition in order that they might be given attention and relieved

of work. In one home a patient might go to her room at any time, and if the work that she was doing had to be done at once she would report to a staff member to obtain relief from duty.

For the most part examinations were made regularly—weekly, biweekly, or monthly. Fourteen homes had all examinations made in the home itself, eight had the patients attend an outside clinic, and two sent them to an outside clinic until late in pregnancy and then had medical attendance in the home.

Three institutions had no record forms for prenatal examinations, and only by questioning the physician and the nurse could any conclusions concerning this important examination be fairly drawn. All the homes claimed that the prospective mother was given necessary instruction about her physical condition. Only one home was found where routine psychometric examinations were made before entrance, though a number of homes referred patients who gave evidence of mental abnormality to clinics for mental examination.

Two places had fully equipped dental clinics to which dentists came regularly. Three had arranged for outside dental service.

CONFINEMENT AND POSTNATAL CARE

In 19 homes the physician that made the prenatal examinations also made the delivery. In 5 these two services were performed by different physicians; however, except in 2 homes, the obstetrician was informed of the history of each case, including the results of the prenatal examinations. From 12 homes patients were sent to hospitals for delivery; in 12 delivery took place at the home. The hospitals used were modern ones and their delivery technique was rated as "excellent" or "good."

Of the 12 homes where delivery took place the obstetrical procedure in 9 was "good," in 2 "fair," and in 1 "poor." Twelve had one or more graduate nurses, and there was an average of 5 patients assigned to each nurse for care. Two had hospital buildings. In two the delivery room was "excellent," and in 2 it was "fair." Two were poorly equipped for sterilization; but all the other equipment for delivery, both ordinary and emergency, was rated "excellent" or "good."

Four homes had no medical record forms—prenatal, obstetrical, or puerperal.

Patients remained in the outside hospitals for an average stay of 13 days, but those of one maternity home returned from the hospital to the home about three days after delivery. Patients delivered in the homes received 14 to 16 days of bedside care.

INFANT CARE

The care of the babies varied greatly; it was "excellent" in 4 homes, "good" in 16, "fair" in 3, and "poor" in 1. In 20 homes the babies were kept in nurseries; in 2 they were in nurseries in the daytime and with their mothers at night; in 2 there was no nursery. As a prophylactic against ophthalmia neonatorum the physicians in nearly all the homes used silver nitrate; argyrol was used in two homes. At the time one home was visited there were in the crowded nursery 8 babies, 4 of whom had acute ophthalmia, and another baby, newborn, in a private room, had a very severe inflammation of the eyes which gave indications of being gonorrheal ophthalmia.

Four homes had no record form for the baby (the same homes which had no record of the prenatal examination of the mother). Births were registered by all the homes.

No training in infant care was given the mothers in 3 homes; in 4 they received only a few demonstrations. In 17 they were carefully taught, and they bathed and dressed their babies every day.

All the superintendents asserted that breast feeding was encouraged, at least for a short time, 10 days being the minimum and a year the maximum period for it, according to the physician's orders. One institution arranged for wet nursing if it became necessary.

The average technique in bottle feeding was good; only two institutions were poor in this respect. Infant feeding was done under the direction of the visiting physician except in 7 institutions where no bottle feeding was necessary because infants under 1 year old either were breast fed or were not kept in the home after being weaned.

In most of the homes the children over 1 year of age were fed milk, soup, vegetables, cereals, eggs, some meat, and bread and butter. Weighing and measuring of the children in these institutions as a check upon their growth and development was not regularly done.

OBSERVANCE OF PUBLIC-HEALTH MEASURES

Not all the institutions conformed to the ordinary public-health regulations. This was due probably to the fact that the superintendents lacked special training and did not realize the importance of these regulations in preserving life and health.

VITAL STATISTICS

The study included 1,492 livebirths and 35 stillbirths. There were four maternal deaths—two caused by pneumonia, one by eclampsia, and one by spinal meningitis.[5]

Among the infants born in the homes or in hospitals connected with them or received into the homes after birth 160 deaths occurred during 1922. Unfortunately, it was not possible to compute from these figures any mortality rate as the data for an accurate count of the numbers exposed to risk at various times in the first year were not at hand. However, for a limited group in 13 homes a comparison was made with the mortality in the State and in the birth-registration area. During the first three months of life, for which alone the number exposed to risk was large enough to be significant, the number of deaths in the homes was found to be 32. This figure contrasts with 16.6 that would have been expected at the rate prevailing in the State as a whole, and with 15.4 that would have been expected at the rate prevailing in the birth-registration area.

ROUTINE AND REGULATIONS

The daily program in the homes varied. The usual rising hour was from 6 to 7 a. m. Meals were served at approximately 7 a. m., noon, and 5.30 p. m., with the day chiefly occupied in cooking, washing, and sewing, and other ordinary duties of the household. Evenings were

[5] These figures do not include information on two homes, one of which was the largest studied.

spent in group recreation or in religious services, which all patients were expected to attend if they were able. There were four exceptions, the two commercial homes, where religious matters were not given attention, and two homes in which as a matter of policy provision was made for sending all patients out to their respective churches to Sunday morning services. Several other homes permitted patients to go out to their churches, but only these two made it a point of general policy. One home made a point of club work and educational work, such as the teaching of English. In two places educational talks and lectures were scheduled for both mornings and afternoons in order to break the monotonous routine.

Formal rules to be observed by persons admitted to maternity homes for care have become less prevalent in recent years than formerly. They were found publicly posted in only 4 of the Pennsylvania homes; in 3 homes patients were required, on admission, to sign copies of the rules; in 17 homes there was an entire absence of any formal rules and regulations. The posted "regulations" seen on each floor of one home referred to the patient's household duties, her responsibility for the care of all the babies in the home, the time which she would spend away from the home for recreation and other purposes—arranged regularly once a week—and the responsibility of each patient to attend her own church.

As in the matter of regulations great changes were apparent in the freedom allowed patients to be absent from the home. In 14 of the 24 homes patients who were dependable were allowed to go out to church, and for various other purposes, unaccompanied by officials of the home.

In almost all the homes a definitely assigned day and hour was reserved as the regular visiting time, usually one afternoon each week. In several places there was but little restriction on visitors; one home limited the time when visitors might be received to one day a month. The superintendent of this place objected to the disciplinary problems created by a general visiting hour and said that it had a disturbing influence on the girls. In two of the homes each girl selected a visiting time once a week and invited any person she wished to visit her. All the superintendents were willing to allow the relatives of patients to see them at times other than the regular visiting hours.

In two hospitals and in the two commercial institutions no supervision was exercised over the mail of patients. In most of the other homes, however, all incoming and outgoing letters were censored or at least carefully observed. Several superintendents used discrimination in the matter, not opening the seals on either incoming or outgoing mail.

TRAINING FOR FUTURE EMPLOYMENT

Only a few homes had definite training courses. Housework was the subject chiefly emphasized, some homes providing definite training in cooking and sewing and other lines of housework. In four homes patients were assigned to work under direction and were given training in this way. Six homes had no program for any training or work under supervision. Some homes had programs of special value, such as that described on page 68; one had a class for training nursemaids, which provided an opportunity for the untrained young mother to prepare for well-paying work and have a home for herself and her

baby during the period of preparation; one home provided a class for nurses' aids, to which unmarried mothers were admitted.

In four homes some attention was given to elementary education, although it was not regular in any of them. Classes provided by sources outside the homes were rarely used. One home sent patients to a dressmaking class in a near-by public school.

Instruction in the homes was given by staff members, by teachers engaged for the purpose, and in a few instances by volunteers.

RECREATION

In most of the homes recreation was limited to group recreation in the evenings, when patients gathered in the living room under supervision of a staff member. All the homes had musical instruments—most of them pianos—and two had radio receiving sets. Two homes that had child-caring departments showed good motion pictures. All the homes planned some outings during the summer months, but only a few had developed any other recreational activities outside of the institutions. Two had well-defined programs which provided for regular attendance at theaters, motion pictures, and concerts for all patients whose condition permitted it, and one other home arranged for patients to go occasionally to the theater. Staff members chaperoned patients at all outside recreation except in one home, where chaperonage was trusted to patients who had been made "trust officers." Meetings of Y. W. C. A. clubs were attended by the patients of two homes. Volunteers planned parties and other recreation in several homes; in one of them a club of the girls gave an entertainment each month. One institution made use of a circulating library. The superintendent of another had a "reading hour," at which standard literature was read and discussed. Many homes, however, had no good books.

DISCHARGE AND CONTINUED SUPERVISION OF PATIENTS

Ten homes endeavored to retain mothers for periods of care ranging from two to six months after the babies' birth, largely to promote breast feeding; five discharged the patients any time after they left the hospital; nine had no set time for discharge, but theoretically at least preferred to have mothers remain through the nursing period.

Thirteen superintendents were willing to transfer cases to agencies interested in them; one held the patient for its required period of stay before transfer—that is, two months after the birth of the baby; one allowed patients over 16 years of age to decide whether the assistance of an outside agency was desired; three settled each case in conference; and two settled each one in accordance with the patient's wishes. Information on the other four was not available.

Discharge was influenced by financial considerations in three homes; two of these homes accepted but did not insist upon six months' service from a mother in lieu of payment for obstetrical care; the other required three months' service from every mother for whom the home placed a baby.

Of the total number of mothers (1,862) accepted during the year 108 left the home before delivery. The chief reasons given for leaving were that the patients were venereal-disease cases and had to be cared for elsewhere, that suitable plans had been made for their transfer to other places for care, or that the patients were dissatisfied with the

home. Dissatisfaction seemed particularly in evidence in one home, where an exceptionally high proportion of patients—14 out of 57—left before delivery.

The homes where the average stay of the patients was shortest kept them for an average of 4 weeks. One home kept its patients for an average of 18 weeks—the longest average stay for the 24 homes studied.

In 17 homes there was an understanding that the mother might return for advice for herself or her child, and several of the hospitals would receive the mother or the baby again if need arose due to conditions resulting from the birth. Two homes had no interest in the physical welfare of the mother or baby after they left the institution. Thirteen homes tried to retain an informal contact by such means as correspondence, return visits of patients, and personal association. Six used local social agencies, but only one of the six had a definite system of referring all discharged patients who were unmarried to a social agency. Three homes included on their staffs workers for this follow-up. One depended on volunteers. In seven homes no effort was made to keep in touch with discharged patients.

On the basis of cooperation with local and State agencies the homes may be rated as follows: Sixteen good, 3 fair, and 1 poor; 4 were too little used by any agency to be rated. Only two of the superintendents seemed to appreciate the relation of their work to the community at large. Most of them thought only of the individual girl and her baby as persons to be assisted by kind treatment, by religious reclamation, and by the observance of a more or less regular orderly routine of household duties. Few homes took active interest in helping to form public opinion or to obtain needed legislation and its enforcement.

PROCEDURE IN PENNSYLVANIA RELATING TO PLACING OUT, ADOPTION, AND SUPPORT OF CHILDREN OF ILLEGITIMATE BIRTH

In the State department of welfare responsibility for all child-welfare work is delegated to the bureau of children. The director of this bureau has a corps of workers who visit institutions, including maternity homes. Regional conferences are held which bring together groups of institutional workers for discussion of their common problems and their varying methods of work. Local child-welfare committees, which are unofficial, have been organized throughout the State to act in an advisory capacity to the State bureau of children.

The Pennsylvania law does not require the formality of commitment with a permanent record for transfer of guardianship for children, nor is there any statutory provision governing supervision of placed-out children by private agencies. Under the adoption statute the entire proceeding of legal adoption of children rests with the courts, the petitioner, and the child's parent or guardian. No definite period of residence in the petitioner's home is required, nor investigation into its fitness, nor of the suitableness of the child for adoption.[6]

The law providing for support of children born out of wedlock provides that the complaint be filed by the mother of the child.

[6] By Act No. 93, Laws of 1925, the court hearing the adoption petition is given power to make an investigation (or to cause some specifically designated person or agency to do so) to verify the statements of the petition and collect such other information as will give the court full knowledge as to the desirability of the proposed adoption.

PROVISIONS MADE FOR BABIES

KEEPING BABIES WITH THEIR MOTHERS

Four homes accepted babies on surrender from their mothers for fees varying from $50 to $250. Three discharged all babies with their mothers, one of these referring to a social agency any mother who wished to dispose of her baby and two insisting that the mother must retain her baby through the nursing period before any other plan was considered. These two homes endeavored to keep in touch with their cases after discharge, particularly those in which there was any question as to the advisability of the baby's remaining with the mother, sometimes, after a period of observation, agreeing to relieve her of the child. In these two homes the nursing period covered at least six months, and the period of o servation was such that babies under 1 year of age were practically never accepted on surrender. Eight homes which had a policy of insisting on breast feeding for varying periods of time accepted babies on surrender after the nursing period if the mothers felt that they could not keep them. Six homes had no definite policy relative to acceptance of babies on surrender, leaving matters to be worked out in each individual case by the superintendent or the board; four of these homes rarely accepted a baby.

In cases of legal adoption seven homes required that surrender be made directly to them; nine homes had policies of having mothers surrender the babies to placing agencies; and four homes required that the baby be surrendered directly by the mother to the foster parent. In one of the last group—a commercial maternity hospital—a singularly indirect method was used. The surrender was signed by the mother before she left the home and the space for the name of the person to whom the baby was to be surrendered was left blank. The names of the prospective foster parents were filled in later when they made application to adopt the baby. The child was thus legally adopted without execution of the mother's surrender of her baby by affidavit before a notary, even this safeguard apparently being waived in some of the courts of record in Pennsylvania.

Of the 1,862 mothers cared for in 22 maternity homes during the year for which figures were obtained 312 were discharged without their babies. Fifty-nine babies were stillborn or had died before their mothers left; 253 were placed in foster homes or boarding homes or were retained in the maternity homes. The number retained in the maternity homes was 146, of whom 120 were surrendered to 12 institutions and 26 were kept temporarily, free or at board, for the mothers. The records of four homes indicated that no babies were kept after the discharge of their mothers and that two of these homes gave as the reason for discharging mothers without their babies the mental defectiveness of the mother. Two instances of this sort occurred in one home, where the babies remained in the institution after the mothers left, and one in another home, where the baby was taken by relatives.

PLACEMENT IN FOSTER HOMES AND ADOPTION

Twelve maternity homes placed 128 children in free foster homes; 8 placed 43 children in family boarding homes. Seventy-four children were adopted from 7 maternity homes; 36 of them were from

one home with a child-caring department not limited to children born in the home. The following tables give the ages of children when placed in free foster homes and in boarding homes:

Ages at which children were placed from maternity homes in free foster homes

Home	Children placed in free foster homes	
	Number	Age at time of placement
1	6	17 days—9 months.
2	3	3—6 months.
3	4	One at 2 months; ages of three not in records.
4	8	14 days to 5 months.
5	7	20 days to 3 months.
6	5	2½—10 months.
7	25	Ages not given (it was stated that children were usually about 1 month old when placed).
8	3	2—7 months.
9	13	1 month—4 years.[1]
10[2]	6	12—16 days.
11	12	Four under 1 year and eight over 1 year.
12	36	Under 4 years.[1]

[1] No differentiation was made as to children of maternity patients and those in department of child care.
[2] A general hospital.

Ages at which children were placed from maternity homes in boarding homes

Home	Children placed in boarding homes	
	Number	Age at time of placement
A	1	4½ months.
B	1	24 days.
C[1]	2	12 days and 22 days.
D	2	2 months.
E	2	8 months.
F	1	Age not in records.
G	29	17 under 1 month—wet nursed; 12 between 1 month and 1 year, all boarded after nursing period.
H[2]	5	2—3 weeks.

[1] A maternity hospital. [2] A general hospital.

The methods used by the institutions to find foster homes varied only slightly. Eight relied solely on personal contacts with friends of the institution; four advertised in newspapers, as well as finding some homes through personal contacts; three referred every mother who wished to place her baby to a children's agency, which dealt with both mother and child. The management of six homes after approving the separation referred the mother to a placing agency or transferred the baby to it.

Fourteen homes placed babies—either directly or through placing agencies—only with persons living within the State. Seven homes had no restrictions as to the State, although five of them used only homes which were accessible for visit (unless the homes were known to be unusually good ones, with favorable prospects of legal adoption).

Three homes placed babies only on the condition that they be immediately adopted, thus eliminating the necessity for any supervision. Four homes did follow-up work, which was, however, so vague and indefinite that it could be of little, if any, value. Eight

homes delegated the work of supervision to children's agencies, five of which did standardized work. One of these agencies, which did the placing and supervision of placed-out babies for two of the homes visited, had all this work done by volunteers—board members, whose services rotated, new members being appointed monthly—so that the children, quite conceivably, might not have had the same visitor for any two visits. No records were kept; these volunteers reported orally to their headquarters, where there was a full-time worker.

One home made a practice of removing from a family any child who had not been legally adopted after a placement of one year. One home having a department of child care continued supervision of children until they were legally adopted or had reached the age of 4 years, when the custody was transferred to a children's agency. One of the hospitals doing child placing had on its staff a nurse with no training in social work, who made all investigations of prospective foster homes, decided with the mothers when babies were to be accepted for placement in boarding homes or in foster homes (without making any effort to develop any other resources for the children), and supervised the placed-out children. She stated that the longest period of time she had ever had to supervise a placed-out baby, before legal adoption, was four months. One institution used volunteers, under direction, for investigation of foster-home applications and for supervision of the placed-out children. Oral reports were made by these volunteers to the secretary of the institution, who added these reports, in her own wording, to the records of the children.

Since there is no requirement in the Pennsylvania law that persons wishing to adopt a child should care for that child in their home for a definite period prior to filing a petition for legal adoption, diversified policies have developed throughout the State. Many of the children's agencies which do conscientious and careful work have developed a policy of requiring a residence of one year in the home before legal adoption will be agreed to, except in unusual cases. A few superintendents of homes followed this policy, believing that it was a statutory requirement.

EFFORTS TO FIX PATERNITY

The records in the homes gave, on the whole, meager information on establishing paternity. In 3 homes the statement given as to the policy followed was that nothing was done to reach the fathers of the babies; in 1, that mothers were advised of the law and its provisions; in 8, that mothers who wished to take action were assisted by being taken to court; in 10, that such mothers were referred to a social agency; in 1 home the information given was so vague that the policy could not be determined; in 1 home each case was settled on its merits. A study of the records of 16 homes in which the records were available for study showed that the records of 6 homes included no information on paternal responsibility, either voluntarily or legally determined; the records of 1 contained certain notations which were too vague to be of any use; and the records of 6 had available data on this point. These 6 homes had cared for 344 unmarried mothers during one year.

In 259 of these cases no efforts were made by the home, either through court action or through private agreement, to establish paternity. An analysis of the action taken in the other 85 cases shows that marriages or agreements of some sort—such as cash settlements—were arranged through private efforts of the home in 16 cases, that court action was taken in 45, and that in 24 some action was taken, the exact nature and result of which were not given on the records. Of the 45 cases brought before the court 22 were still pending at the time the records were studied. What action was taken in regard to 26 was not stated. Orders for support, varying from $1 to $7 a week, had been entered in 10 cases; settlements of $300 in 5 cases and of $500 in 1 had been made; marriages had taken place in 2 cases; in 2 cases the men involved had been sentenced; and 1 case had been dismissed.

These figures are taken from records, but for several reasons they do not present a complete report on the outcome of the efforts to establish paternal responsibility. In some homes which referred the establishment of paternity to outside agencies the action taken and its results were not entered in the records; in other homes the action was entered, but not the result, because the patient had left the home before a decision was reached. It is quite probable, also, that a certain number of the putative fathers, either directly or through the mother or her family, paid hospital expenses, although the mother had been accepted as a private patient, or, in some of the maternity homes, the regular rate. It is possible that some men paid the surrender fees in homes in which babies were accepted under this arrangement.

DESCRIPTIONS OF INDIVIDUAL HOMES[7]

Home I

This home was well located in a beautiful suburban section of a city. The main building, formerly a handsome residence, had been equipped for maternity-home use without regard to expense. There were two smaller buildings. One of these had been converted into an infirmary, and it had provision for necessary isolation. It was modernly and even elaborately equipped, so that it might be operated with a minimum of workers. The glass-walled ward and cubicles made it possible for the trained nurse to supervise the entire corridor. The well-arranged facilities, such as sterilizer and utility room, baths, and laundry, made it easy to manage the routine. The steam-laundry equipment included a small vat for antiseptic solution. The sleeping apartments were in suites with baths in each. There were never more than three persons in one room and never fewer than two (except in isolation rooms), so that sleeping quarters were not crowded and bathing facilities were adequate. Minor operations were performed in the infirmary, as it had facilities for emergencies. There was no delivery room, the patients going to a modern hospital, where the best confinement care is given. They were brought back from the hospital in a few days and were cared for in the infirmary during convalescence. The other building was a small cottage in which a group of older children lived with their mothers.

[7] Besides the homes studied an institution was visited which, although not really a maternity home, met a distinct need in the field of maternity-home service. Other provisions in the community for prenatal care made it unnecessary for this institution to accept any appreciable number of "waiting mothers," but it rendered real service to new mothers, many of whom needed convalescent care, which is not supplied in most maternity homes and which is inadequately provided for in nearly all communities. Ideal physical equipment, occupational therapy, provision for teaching the care of babies and some branches of household work, all made for the satisfaction and gain of the patients. A routine was arranged for each patient individually according to her strength. The presence of a special "mothers' building" in this institution, with unmarried mothers accepted on the same basis as married mothers—that of patients needing convalescent care—constitutes a valuable asset in this field of work.

The grounds were most attractive. They were well equipped for recreation for mothers as well as children. A vegetable garden was provided, as well as flower beds, trees, and shrubbery, and small individual or group flower gardens for which children made themselves responsible. The products of the children's gardens were always their own.

Originally the home was a child-caring institution housed in a down-town section of the city. Among the children admitted for care then were babies of illegitimate birth who had been early separated from their mothers. The superintendent in charge at the time of the study had formulated plans for receiving the mothers with the babies. Her reason was twofold: To help meet the mother's need for assistance in the trying experience of illegitimate motherhood and to conserve for the child the invaluable asset of nurture and care by his mother. Accordingly, the board of directors decided in 1916 on this addition to the work. At the time of the study the home had two departments of work—the maternity home and the department of child care. The latter was not limited to care of children of the mothers in the home, but was a general child-caring home.

The home was part of a local federation of charities but had a separate board of directors. Besides the superintendent, the staff included an assistant superintendent, five graduate nurses, a dietitian, and a house mother. Funds were raised by the federation of charities. A pro rata sum was paid by the county for committed children. No rates or fees were charged the maternity patients though any mother whose circumstances permitted might make a contribution to the home.

Admission restrictions were very few. Only white women were admitted, and none with any communicable disease. Most applicants were received through cooperating social agencies, and they had had an examination showing that they were free from infectious disease. However, isolation facilities were maintained, and a complete examination was given by the attending physician. Girls in pregnancies other than the first who had been cared for elsewhere or even in this home previously were admitted if there were no girls in the home who knew them. No distinction was made between married and unmarried women, although few married women applied for admission.

Prospective mothers were admitted at any time. The superintendent preferred having them enter early in pregnancy. Mothers with young babies were also admitted from hospitals. Preliminary social investigations were not always made, though case investigations were part of the routine. These investigations included visits to relatives if they were living in accessible places. On admission patients were asked to remain for one month after delivery (except the few committed girls, who understood that they were obliged to remain longer). At the expiration of that time, or just before, plans for further stay were made by the superintendent with the girls.

Though the capacity was 35 mothers and their babies, the total number of mothers cared for the year before the study was 56. A number of cases were noted in which girls who could not adjust themselves to other institutions were sent to this home by courts and from private sources. This group included a few delinquent girls with sex experience.

Thorough physical examinations led to the correction of many defects, and the best possible preparation was made in each case for the unborn child. If a patient became toxic, she was sent to the infirmary and was placed under special care by a physician.

Dental attention was given whenever necessary, and an ophthalmologist gave part of the specialized care which the patients received. Psychometric examinations were included in the routine, and the service of a psychiatrist was obtained if needed. If it became necessary to have after-puerperium care the mother and nursing baby might return to the infirmary.

Breast feeding was the rule. There were several factors contributing to its success, including a pleasant, healthful rural environment and hygienic preparation for confinement. The fact that the length of stay in the home was determined entirely by consideration of the future welfare of the mother and the child was a determining element in the mother's mental attitude.

The diet of this home was classed as "possibly inadequate" (see p. 6) for both pregnancy and lactation and was regarded as probably the poorest phase of the work. In an effort to insure contentment and cooperation the girls were allowed to eat the food to which they had been accustomed in their homes. For example, no citrous fruits were served at breakfast because the girls did not

care for them. The menu for at least one meal a day was chosen by the girls. Though such a practice might help to make them contented, it is, nevertheless, not a practice that would lead them to eat properly for pregnancy and lactation. As the children had no such inclinations to overcome, they were fed according to good judgment. A garden on the premises furnished fresh vegetables in abundance during the summer.

The best understanding of public-health measures was shown here of all the places visited in Pennsylvania. The members of the staff not only observed ordinary prophylaxis but seemed to know why they were doing so.

Physicians gave lectures to the household regularly upon different subjects—emergencies, personal hygiene, and general rules of health, as well as some technical lessons in first aid—to instruct those who probably had never had any training in physiology and hygiene. At the close of the lecture there was often a demonstration and a quiz. The superintendent believed that such instruction, the subjects of which were chosen to meet the needs of pregnant women and nursing mothers, had a greater weight when given by the visiting physician than when given by herself and the trained nurse.

The policy of the home was to foster the mother's responsibility with a view to procuring for the child permanent care by his relatives and also for the moral influence on the mother. Among the 43 cases discharged the year before the study there were only 2 separations of babies from their mothers. In both cases of separation the mothers were mentally defective and were committed to institutions. These babies were retained in the home, on surrender by their mothers, to be cared for until their mentality could be studied and permanent plans for them decided.

Effort was made to fix paternal responsibility. The superintendent endeavored to see the fathers and have them come to the home to see their babies. She stated that in about one-third of the cases the fathers either voluntarily assumed responsibility for support of the baby or were compelled through court action to do so.

The daily routine practically covered the day from the rising hour (6 a. m.) until 7 p. m. Besides the meal hours a break of two hours was provided in the morning and again in the afternoon. These periods were used for varied purposes—rest, lectures and conferences, recreation, or personal pursuits.

Assignments to the work of the home were correlated with plans for training the mothers for future employment. This home had unusual provision for this preparation. There were seven distinct lines of training: Care of babies; care of older children; housework and sewing, including operation of power sewing machines, cooking, and laundry work; industrial art; and special types of preparation selected by the girls with the help of the superintendent.

The courses of training were given under direction of the staff. Care of babies was taught by nurses; housework, sewing, and operation of the power sewing machines by the house mother; cooking by the dietitian; the course in training as a child's nurse was given by doctors and nurses; industrial art was taught by the superintendent; laundry work by an employee who was in charge of that work under supervision of a staff member. The course in the care of babies was the only one which all patients were obliged to take. Any of the others were chosen in conference with the superintendent, according to each girl's aptitudes and inclinations. An instance of special preparation for future employment is that given three girls living in the home with their babies at the time the study was made. They were attending a preparatory school to complete high-school work, which was required for positions which they expected to fill later.

Instruction was provided for girls who had not had even rudimentary schooling. At the time of the study the services of a volunteer teacher were utilized, while the management was endeavoring to procure assistance from the State department of education. When the home was located in the city girls had attended night classes in the public schools.

The average period of stay in the home was about 18 months, so that most of the girls had ample opportunity to complete several of the courses.

All the girls in the home were urged to become members of a club that had as its purpose self-government and recreation. The club planned and carried out entertainments in the home and arranged for outside recreation. The members were instructed by the staff in principles of social organization and management.

Much freedom was permitted. Recreation was well planned, the program including entertainments within the home and also attendance at concerts, plays, and motion-picture shows. A great deal of time was spent out of doors, both in work and in recreation. Although patients were permitted to go out alone for

certain purposes, the recreational activities outside of the home were usually arranged for groups accompained by a staff member. The home had a very liberal policy of arranging for attendance at religious services; any clergyman might come to the home by appointment for conference with one or several of the patients of his religious group. Girls went usually unaccompanied to their respective churches. The staff appointments were made with a view to having on the staff Catholic, Protestant, and Jewish officers for contacts with girls of their own faith. This deference to religious practices is a most significant departure in maternity-home work.

No formal regulations were posted. No general visiting day was set, but patients selected one afternoon each week and invited their friends to call at that time. This obviated certain difficulties resulting from bringing together relatives and friends of different girls and protected the privacy of each one with her own people.

Particular attention was given to mentally defective patients. An effort was made to make their families realize the need for close supervision or for institutional care when that seemed suitable. The management of the home was keenly interested in all methods of devising the best care for its charges. The staff and the board members also manifested intelligent interest and cooperation in community plans, social legislation, and general social service.

The record system was very efficient. Narrative histories were used, chronologically arranged. Those which were examined—records for about half the patients for a year—were succinct and informational. At the beginning of the history was placed the "mother's statement." This is a unique addition to social histories. It was made up by the superintendent after she had gained the confidence of the patient, usually after a residence of some months. All those read by the Children's Bureau agent contained simple, definite statements and seemed to be valuable contributions to the records.

Home II

A residence building in a crowded city block was used for this home, and these housing conditions brought about some difficulties in management. The building was in fair condition, but it needed some repairs. The furnace was not always adequate for cold, windy days, and it was supplemented by a kerosene stove with no vent for noxious gases.

The staff was small. and the members of it were not highly trained, but they were sympathetic and kind to the patients and cooperative with the physicians in attendance on them.

Patients with venereal disease were not admitted if the infection was known. but as the physical examination was not given until a few days after entrance such patients might have been admitted and might have lived in the home for a while before the infection was detected. Isolation facilities were poor, the only provision being a small room containing two beds, one for a child and one for an adult. No separate toilet or bath was provided for patients with venereal disease. The only precaution against the spread ot infection was scrupulous cleanliness.

Soon after entering the home each patient was given a physical examination at the cooperating hospital, and she then began attending the hospital's prenatal clinic. The suggestions made at the clinic were carefully carried out at the home. The same hospital received the patients for confinement, giving them careful attention and using the most approved technique. Six weeks after delivery each patient returned to the hospital for final examination.

The babies were given painstaking care, but it was hardly up to modern standards. For example, unless a baby was noticeably ill or required special feeding directions he might not be seen by a physician for months.

The diet was rated as "probably inadequate" for pregnancy and "probably adequate" for lactation. Breast feeding was encouraged and supervised.

All babies were discharged with their mothers. For this home this procedure did not seem best, because the home had no trained social workers to keep contact with certain types of mothers who needed supervision after discharge.

Local agencies found the home willing to cooperate with them—perhaps too willing, for younger girls who were not maternity cases were sometimes accepted at the request of the agencies. The home had no provision for segregating different types of women, and its policy of placing inexperienced girls or even certain types of problem girls with unmarried mothers seemed unwise. The

home was a member of a local federation of social agencies and received funds from it. This membership was a good feature of the work, as it indicated that the home took part in community activities.

The superintendent exercised common sense in dealing with the patients, allowing them to attend their own churches and to have recreation outside the home. She also allowed those who did commercial work to keep part of their earnings.

Home III

A building which was formerly a private residence had been enlarged and otherwise adapted for this home. It was on a crowded city street, but this disadvantage was partly offset by the fact that it was near a good prenatal clinic and well-baby station. The living rooms, dining room, and kitchen were light and pleasant. The sleeping quarters were crowded and probably were the poorest feature of the house.

A lack of isolation facilities placed the patients rather at a disadvantage, as a newcomer might remain several days before a physical examination was made.

Either at the near-by clinic or at one of the many excellent hospitals in the city the expectant mothers were given suggestions on prenatal care. The superintendent was not enthusiastic about carrying out these suggestions, as she had not been trained to value scientific help. The home had no graduate nurse or other highly trained person on the staff, and some of the medical policies were obsolete. The diets for both pregnancy and lactation were rated as "probably inadequate."

The cooperating hospital sent an ambulance to the home for each patient at the onset of labor, and the confinement and puerperal care were excellent. The patient returned to the home 12 to 16 days after delivery and received special care there for at least two weeks longer. If a toxic patient did not improve promptly in the home under the regimen prescribed she might return to the hospital for an indefinite period.

The children in the home were under the supervision of a nurse and a doctor at the hospital's health center, and suggestions for infant care were sent to the home. An outline of diets for an infant under 1 year was furnished by the center, but, as in the case of prenatal care, the cooperation at the home was desultory.

The house was fairly homelike. The "parlor" was used by the patients only for religious services, group singing (usually part of a semireligious meeting), and similar purposes. The living room was small and was inconveniently situated near the rear on the second floor.

The social policies were poor. Most of the babies were separated from their mothers soon after birth. Of a group of 11 mothers cared for during the year of the study the babies of 7 were taken for placement at ages varying from 14 days to 5 months, the maximum age in all but two cases being 2 months. The placement of these babies was delegated to an agency with no conception of modern standards of work, though there were at least three agencies in the city doing good work in child placing. This was an example of the general social policies of the home.

One of the members of the board of managers stated that they believed they had evolved "the best possible method of caring for these girls and their babies."

Agencies doing standardized work used this home rarely, and only for temporary care for brief periods.

Home IV

This home, which was much larger than most of the others studied, included a maternity home, a maternity hospital, and a department for the care of dependent children. The building had been planned especially for its work, and it was well arranged in all three departments. The dining rooms, kitchen, laundry, bakery, and refrigerating plant were well equipped. The baths, toilets, and washbasins had excellent plumbing and were adequate in number for the large household.

Large dormitories were used for both waiting and nursing mothers. They did not seem crowded, as the beds were far apart and the ceilings were high. The isolation suite consisted of four single bedrooms, with bathing and toilet facilities for four patients awaiting examination. Patients with venereal disease were not accepted except in emergency. A number of such patients, on the verge of labor, had been received and had been kept as long as was necessary.

The superintendent was a graduate nurse and was a person of ability, progressiveness, and charm. Two other graduate nurses were on the staff. The administration of the institution showed good teamwork. One of the best hospitals in the city had arranged for rotating service by resident physicians. A dentist was employed and complete dental equipment was provided.

Pregnant women had a prescribed rest period every day. The prenatal record was carefully kept by the resident physician, and any unusual condition was brought to the attention of the chief of staff. Minor operations only were performed in the institution; laparotomy was done at an outside hospital.

The babies and older children were weighed and measured regularly and the results recorded and kept. A trained nurse had charge of this work under the direction of a pediatrist. The diet in the maternity home was rated as "possibly inadequate" for pregnancy and "probably adequate" for lactation. Diets were differentiated according to physicians' orders. Every toxic patient was put in the infirmary and was kept on a strict dietary regimen. In the puerperium in case of a rise of temperature or offensive lochia the patient was isolated at once and a special nurse was placed in charge of her.

Appreciation of the advantages of employing modern technique had led to the opening of a social-service department. Visitors were permitted to call any afternoon and at certain other times, so that undesirable mingling of visitors and the peculiar atmosphere incident to general visiting were avoided.

Certain points in the social policies were not commendable, such as the large group system of care which resulted in contacts between younger girls and those older in years and experience; the practice of retaining some mothers for long periods of care, although the home offered no preparation for future employment save domestic work and plain sewing; and inadequate follow-up work. Development of social service should improve some of these conditions.

The records were carefully kept, though they did not include as much information as the modern case history. The staff appeared to be well prepared for their work. They were active in continuing formal studies—working for degrees, and attending local, State, and national meetings of social workers.

Local agencies found the home very cooperative.

Home V[8]

It was difficult to judge this home according to the usual standards for maternity-home work. Its purpose was to care for colored unmarried mothers and their children, and its founding was apparently an expression of racial responsibility for these women and children. It did not seem to fill a great need, for the number of persons cared for was very small. At the time of the study only three women (one a boarder employed all day) and eight children were being cared for in the home. As the other child-caring institutions of the city accepted children without question of race, it would seem as though the child-caring department of this home was not greatly needed.

The equipment was poor and the surroundings unhygienic. The superintendent was untrained and her resources were very inadequate.

The patients were given prenatal care at health stations or at hospital clinics. A practical nurse, available on call, gave volunteer service. Several good hospitals received the patients and gave them the best of care. Upon their return to the home the superintendent allowed ample time for their return to normal health.

The diet was rated as "probably inadequate" for pregnancy, but the effort that was made for the mothers and their children is shown in the rating for the diet for lactation—"probably adequate."

No home records with which to check up the work done or the results obtained were available, and the medical records at the hospital were merged with too many others to be studied.

Local agencies, though realizing the limitations of the work, used this home in emergencies as a detention place, having confidence in the integrity of the superintendent's motives. The home's refusal to accept "innocent girls" because of the dangers of subjecting them to contact with the others was commendable.

Poor methods of discipline and absence of records were among the more serious defects of the home's work. The superintendent did not know the number of placed-out children supposedly under her supervision at the time of the study, admitting that she "loses track of some."

---

[8]This home is no longer in existence, as its charter has been revoked by the State.

Home VI

This home, established in recent years for the care of dependent children, in a rural community already well provided with such institutions, had later undertaken also the care of unmarried mothers and of other women. On account of the limited capacity of the building, it would seem wise for the home to have concentrated on one kind of work instead of attempting three.

The rooms were crowded but were all in good order and scrupulously clean. There was only one bathroom, and its toilet, washbowl, and bathtub were used by the entire household, which at the time of the study consisted of 10 adults and 21 children.

The staff was composed of persons who in the opinion of local social workers were utterly unsuited for the work which they were doing by reason of personality, point of view, and lack of education and of training. One member whose time was divided between collecting money and visiting prospective foster homes and the persons given as their references was called the social worker. The staff members were not highly trained for their medical work but were very cooperative with the attending physicians. Undergraduate nurses were employed. A physician, who came upon call, safeguarded the health of the patients very well. Those with venereal disease were detained at a hospital until the disease was rendered noninfectious. The physician did not intend patients with such infections to be received at the home; but they were sometimes received from other agencies and the physical examination was made afterwards. There were no facilities for isolation, but partial segregation was obtained by putting an extra bed in the matron's room.

Prenatal oversight was exercised by a good, modern hospital, where the deliveries were made in accordance with the best procedure. The patients were kept at the hospital throughout convalescence, so that bedside care at the home was not necessary. Breast feeding was required for at least two weeks; but it was not always supervised, and dissimulation would have been very easy. The diet was rated as "possibly inadequate" for both pregnancy and lactation. If a pediatrist was needed the child was taken to a health center, as there was no special service of that kind at the home. All the health records that were kept were at the hospital; none were available at the home.

The business organization promised extensive development. Support, moral and financial, was being developed in many quarters. But the home's uncooperativeness with all local social agencies, its lack of confidence in them, its attitude toward official supervision, and the staff's ignorance of modern methods of social treatment, all gave the impression of a home of questionable character.

Home VII[9]

An entirely commercial enterprise, this home represents a type of institution different from most of the others studied. In at least one detail it conformed with recognized standards, as it was one of the few homes in the State which were found to be licensed. It provided hospital care and maternity-home care, boarded children, and placed them in foster homes, accepting the custody of babies for placement on the payment of a certain sum by the mother.

The proprietor, who was also superintendent, was a practical nurse, and she was assisted by undergraduate nurses; no graduate nurse was on the staff at the time of the study. The proprietor's personality did not seem to recommend her for work requiring character, dignity, skill, and sympathetic understanding, such as maternity-home work. The babies were in charge of a colored maid.

Toilet and bathing facilities were inadequate for the number of patients, as there was only one bathroom, with one tub, one washbowl, and one toilet, for the whole household, which at the time of the study included 24 adults.

Prenatal care was directed by a physician who called at regular intervals. Deliveries were made at the home in a poorly equipped room without proper facilities for sterilization of supplies. There was but scant equipment to meet emergencies and no surgical equipment except that for lacerations. No record of physical or obstetrical examinations was kept. A labor record and a clinical sheet, kept by the nurse, were the only medical records seen by the bureau agent.

---

[9] Since the time of the study the work of this institution has been gradually changing and general-hospital work has been largely substituted for maternity-home work and child caring.

No isolation facilities were provided for cases of infectious disease. Of a total of eight babies in the nursery four had acute ophthalmia; another baby in a private room had it also. No apparent precautions were taken to protect babies not infected.

Patients with venereal disease were not treated, the claim being made that they were excluded. There was no evidence that such infections were detected, and no precautions were taken to prevent their spread.

The mothers slept in the dormitory on the third floor and took their babies to bed with them at night. There was no supervision of the nursing of the babies. The majority were artificially fed. Sample menus were not obtained, but the superintendent said that private patients paid for proper, adequate food, and that the entire household was supplied alike.

The proprietor claimed that the primary function of this institution was to give hospital care, chiefly to married women, but by its advertisements in newspapers and by other means it called attention to the protection it gave unmarried mothers and to its acceptance of the care of infants. No effort was made to do constructive work with the unmarried mothers. A recognized social agency in the city occasionally used this home, and the superintendent made the most of this connection to improve the home's reputation.

Home VIII

This home was part of a national organization, and the policies were formulated at national headquarters and in the general conference of workers, leaving the management of the home freedom and responsibility in matters pertaining to individual work as far as was consistent with these general policies. Originally planned for the work of "rescuing girls," this home has also developed a department of child care. None of the staff had given any thought to the origin of the latter work, and they were unable to state when or why it had been begun. The home also gave maternity-hospital care. The various records were regularly kept, though social case histories were inadequate in content, showing that insufficient work had been done in investigation.

The building was a converted residence in a suburban section, well adapted for the types of work done by the home.

All the medical care was given in the home by a physician who lived nearby and came on call. Besides this physician a pediatrician was on the staff. The superintendent, her assistant (a graduate nurse), and other trained employees cooperated well with the physicians.

At the discretion of the nurse, new patients were isolated until they had been examined by the physician. Isolation was maintained on the second floor by means of separate toilet, bath, and sleeping facilities. The physician's examination was usually given within 24 hours. The Schick test was given to new patients because the home had once admitted a patient with diphtheria without knowing it. It was claimed that the home did not receive patients with syphilis, but the Wassermann test was not made until the placental blood was obtained. Gonorrheal patients were kept and treated.

Records of the prenatal, obstetrical, and puerperal examinations were kept. The physician or the nurse, who was a midwife, delivered the patients. Complicated cases involving surgical interference were sent to an excellent outside hospital. The nurse performed urinalysis weekly.

The patients were cared for in the home throughout convalescence after delivery, great care being taken in case of a low-grade infection or other retardation of recovery. The diet was rated "probably adequate" for both pregnancy and lactation. After leaving the home the girls might return at any time for help, advice, or rest.

The staff had the usual kindly characteristics of workers in the organization which operated this home, and they manifested a spirit of service which was perhaps responsible for the home's being filled to capacity—a condition rare among the homes studied. This institution also served the immediate community well, as the nurse was accustomed to go out to help local physicians in emergencies when no other nursing help was available.

The home was not extensively used by local social agencies. One objection was that the patients received hospital care within the home, most workers preferring to use homes that sent their patients to general hospitals. Virtually no efforts were made to fix paternity. Babies were placed by an agency doing very poor work, and under these circumstances the home's policy of accepting babies readily on surrender was questionable.

Home IX

This home represented a work of long standing for the moral rehabilitation of women. It presented an unusual combination—the care of unmarried mothers and the care of aged women. Care of the aged had been developed in recent years, and for this work a wing had been added to the building.

The house was not particularly well arranged for a home of this kind, as its dormitory and bath for both waiting and nursing mothers was on the third floor. The bathroom had one tub, one toilet, and four washbowls. Individual bath towels were provided, but not individual face towels. The dormitory was crowded, with barely space to pass between the beds.

There was no provision for segregation, and the superintendent claimed that she did not admit any patient that had venereal disease.

There was no highly trained person on the staff, and the medical care seemed haphazard. Only if a girl "looked delicate" was she excluded from the work of the dining room or the kitchen. A physician, who came upon call, made a physical examination, but no record of it was kept. The obstetrical examination was made at one of the various clinics and hospitals used by the home—often at the hospital where the patients were delivered.

During convalescence every mother was well cared for, and she was prepared to nurse her baby and take all responsibility for his care. The practice of having the babies sleep with their mothers in the dormitory was a poor one.

The diet was rated as "possibly inadequate" for both pregnancy and lactation; but it may be that there should be a shading toward "probably adequate," as the amount of milk used was not accurately computed. Apparently breast feeding was usual, though no records of the care of the infants were kept.

The fact that the home did not require the mothers to stay a fixed period indicated a flexibility in procedure which was perhaps offset by the requirement that each woman sign a set of formal rules before admission to the maternity-home department.

A certain amount of training in domestic work was given. Practically no effort was made to fix paternal responsibility. Any mother who objected to keeping her baby after discharge had to leave the home with the baby, as the home would not make any provisions for them. Financial conditions did not enter into the procedure.

Though the limitations of the work were recognized by local agencies, the home had their confidence, and it was used by them because of its cooperative attitude.

Home X

Housed in a modest building, plainly (though comfortably) furnished, with a superintendent of only elementary education and no training for her work, this home, nevertheless, was outstanding in its fine spirit and its appreciation and use of modern methods and resources.

The place was an illustration of good work without great expenditure. The house was being improved as to heating and other modern conveniences. It provided bedrooms with two single beds in each for the waiting and nursing mothers. The health and safety of the inmates were well safeguarded. All patients on entrance were examined and segregated for three weeks in order that the mothers and babies already in the house might not be exposed to infection. The home cooperated with a number of hospitals, and all examinations, even urinalysis, were made at outside clinics or hospitals. Recommendations made at the clinics were carefully followed at the home. Two of the hospitals sometimes sent a nurse to the home to report on the condition of a patient late in pregnancy, if it was too great a task for her to go to the hospital. If a patient was toxic she was placed in the medical ward at a hospital and remained there until all symptoms subsided. She was then kept on a strict regimen in the home. Upon return after labor the patients had good care and were not expected to resume their regular duties for four weeks after delivery.

The care of the babies in the nursery was noteworthy. The superintendent slept in a room opening from the nursery and called the mothers in the night to nurse their babies. The babies were soon trained not to be nursed between 10 p. m. and 5 a. m. The diet of the mothers was rated as "possibly inadequate" for pregnancy and lactation.

Though the mothers in this institution were usually there for a short time only, the wholesome atmosphere, good medical standards, and close association with the superintendent and her assistant must have been a valuable training

for the patients. It was recognized that the patients were under considerable and unusual strain, and allowances were made in every way possible. Throughout the study board members and other persons connected with the home manifested a fine humility, in contrast to the complacency noted among persons connected with some other institutions. The combination found here of the appeal of emotional religion with modern social procedure is very rare.

Early in the history of this home the board and other interested persons were divided in opinion as to whether the babies should be cared for by their mothers or placed in foster homes. Feeling was intense on both sides; the decision was to keep the babies with their mothers.

The social-service exchange was used; in the main, cases were referred to social agencies for investigation, efforts to fix paternal responsibility, and follow-up. Training for future employment was practically limited to domestic work, but this training was fairly thorough. The patients were employed to some extent at commercial work, all the income from which went to the home. Not a great deal of such work was done in this home, but the practice of the home's keeping all the money earned by patients is undesirable. At least part of this money should go to the patients.

Home XI

The first impression on visiting this home was of a very happy place. The superintendent had a unique personality. She had a background of education and natural refinement, a gift of imagination which was a distinct asset in discipline, and a cooperative attitude toward all community agencies, but with these she combined a certain sentimentality. She also combined religious zeal with the modern nurse's good technique and cooperation with medical service.

The house, a converted residence, was well adapted for the work of a maternity home and hospital. The rooms were all pleasant, comfortably furnished, and clean, making the impression of a very pleasant home. There were two bathrooms, one in the delivery suite for the use of the staff and the other for the patients. There were modern appliances for the work of the household in basement and kitchen. Low gas pressure was a great trouble, especially in the sterilization of supplies for the delivery room.

The home did not keep any patient with any communicable disease, and every applicant was supposed to bring a clean bill of health with her. A physician, who came upon call, made a physical examination as soon as possible; and if gonorrhea or syphilis was found the patient was transferred for treatment until the disease was rendered noninfectious, when she might return to the home. The physician made the obstetrical examination, and the prenatal care was definitely outlined, with the home cooperating. If a patient became toxic she was sent to a hospital, as she would be for any illness requiring bedside care.

Delivery was made in a room adapted for that purpose. The patient remained in the bed used for delivery through the puerperium and then was placed in one of the rooms on the second floor, to remain until the baby no longer needed to be nursed at night. Waiting mothers slept in a dormitory on the third floor.

The bedside care after delivery was one of the important factors in the management of the home. Every effort was made to restore the patient physically and to teach her to realize her social responsibilities. Most painstaking care was given the babies, though no record was kept of it. No health records of any kind were available.

An eye, ear, nose, and throat specialist was on the staff and did the work referred to him by the attending physician.

The diet was rated as "possibly inadequate" for both pregnancy and lactation. More modification than was shown in the menus may have been made in the diet for nursing mothers.

In the main, modern social methods and policies were followed; still there was an unwillingness to use the confidential exchange of information, as "it exposes families." The girls were fairly well trained in cooking and housework; they were taught the care of their babies, and some educational work was done, particularly in English. Their appearance was neat and attractive. Evidence of daintiness in the home was striking, especially at meal times. The quiet, pleasant, apparently unrestrained conversation would impress a visitor favorably. Recreation was given due attention.

Though this was one of the few homes filled nearly to capacity when visited, the total number of girls cared for during the previous year was smaller than would be expected.

Shortly before the study the chronologically arranged, narrative social history had been introduced. These histories were found to be very poorly kept.

The home had the confidence of the local agencies. Workers, though realizing certain defects and limitations, used it with very satisfactory results.

Home XII

This home was a purely commercial institution, operated by a man with no medical nor social training who seemed utterly unfit for such work by reason of his personality and characteristics. Patronage was obtained chiefly by circularizing physicians. The circulars were alluring in their promise of "seclusion and privacy for unfortunate girls." As would be expected, the babies were an important factor in the commercial transactions. They were taken at any age—at birth, if it was requested, the mother never seeing her child. Babies were placed out and legally adopted, as rapidly as possible. An attorney was employed to see that the home did not violate the law.

This institution was a branch of a much older one under the same management in another State. A conditional license had been granted the older home by the State, but the year of the study this license had been withheld. The proprietor had, therefore, established another home in a State which placed fewer safeguards about mothers and babies. All the information gained about this place was disparaging to it from the point of view of sound social procedure and policy.

The building was not well adapted to the work, though improvements were being made in the sleeping quarters. It conformed to certain city health regulations. The house staff had only one trained member, a graduate nurse. A contract physician came on call. No precautions were taken against admitting patients with venereal disease, although the management claimed not to receive anyone with any "obnoxious disease." No effort was made to ascertain whether kitchen or dining-room help were free from infections.

The prenatal care was outlined by the physician, and brief records of obstetrical history and labor procedure were kept. A chart of the puerperium was kept by the nurse.

Delivery was made in the home in a fairly well-equipped delivery room. No record was kept of the infants except date of birth, weight, and general appearance. The babies were nursed one week; the mothers usually left the home two weeks after confinement. The diet was rated as "possibly inadequate" for both pregnancy and lactation.

Home XIII

A certain apathy marked this home. It was manifest in the listless attitude of the mothers as well as of the staff and in the general atmosphere. In a city of more than 100,000 population this was the only institution for the reception of older girls and women needing temporary care, and it might have been filling its function extensively and efficiently. But this was impossible while the activities were directed by the managing board in charge at the time of study. Although the home could accommodate 9 adults, only 17 were cared for during the year preceding the study. In an attempt to stop the continuous dwindling of the number of patients the required period of stay had been shortened and provision had been made for the care of types of women not previously admitted. Maternity cases from a State school for girls were received.

A residence in a pleasant street, near a good hospital, was used for this home, and the building was well adapted for the work.

No highly trained person was on the staff, but a physician came on call and had given good service for years. The superintendent, who was also the housekeeper, was overworked; and she was worried about the danger of admitting patients with venereal disease, for she had not the training nor experience to cope with that problem. She seemed glad to leave to the hospital all matters pertaining to the patients' health.

Each applicant was detained in isolation until a complete physical examination was made, and an obstetrical examination was made at the hospital as soon as convenient. There were no records available of examinations or prenatal

history. The patients were delivered at the hospital. Though no records were kept, any abnormality was brought to the attention of the chief of the obstetrical staff by the hospital's resident physician.

The patients usually returned to the home 14 days after delivery. If need arose for any patient to return to the hospital she might take her baby with her. Breast feeding was encouraged, but it was not insisted upon. The diet was rated as "probably inadequate" for both pregnancy and lactation. The amount of dairy products used was very low.

The patients were given mental tests at a clinic in the city, and the superintendent relied a great deal on the results of these tests in dealing with the patients.

Apparently no social policies had ever been formulated. Provision for recreation was meager; patients were given no training for future employment; and little effort was made to fix paternal responsibility. The formal rules of the home, a copy of which was given to each patient on admission, were not such as would inspire confidence in the home or develop a desirable mental attitude in the patients.

Relations with a good case-working agency had recently been established. The superintendent was in advance of her board in utilizing resources, made available through this agency, for improving individual treatment and for developing standards and policies of work.

Home XIV

An unusual combination of conditions existed here. Parts of the house were attractive, and parts unattractive. The superintendent, whose preparation was limited to practical experience in institutions, had certain excellent qualities. A pleasant spirit was manifest, all the patients calling the superintendent "mother" of their own accord. However, her assistant, a practical nurse, did not cooperate well with the physicians in attendance, and better work should have been done for the babies.

The house was only fairly well adapted for the work. Double beds in the dormitories were used. The patients had only one bathroom, and it was on the third floor. The staff had one on the second floor, the toilet in which was often used by the patients. The patients had a separate dining room, which was less attractive than the one for the staff. The same food was served in the two dining rooms.

Every girl committed to this home by a court had had a complete physical and mental examination. Other patients were kept in isolation until a physician came to the house and made an examination. A Wassermann test was not given, but if there was evidence of a venereal disease the patient was sent away for treatment until the disease was rendered noninfectious. In case of acute infection isolation might be improvised at the home and a special nurse arranged for.

The obstetrical examination and the prenatal care were given at the hospital clinic, which the patient attended according to the orders of the physician there. Recommendations made at the clinic were not always carried out at the home. The patient was delivered at an excellent modern hospital, and the puerperium was well safeguarded. If the patient had not attended the clinic at the hospital regularly she entered for confinement as an emergency case, for the attending physician at the home was not a member of the obstetrical staff of the hospital. No health records were available at the home for either mothers or children.

The diet was rated as "possibly inadequate" for both pregnancy and lactation. The superintendent intended that nursing mothers should nourish their babies adequately, but the feeding was not always supervised.

Through the cooperation of a local agency, two departures of significance had recently been made: A day nursery operated by the home was closed after a careful study had been made to ascertain the reason for a steady decline in its use, and the funds formerly used for the day nursery were used to pay the salary of a trained worker who was added to the staff to make social investigations and to formulate plans for mothers. For several years the policy had been to refer to a social agency all babies to be placed.

Several points in the management of the home were notable. Outside recreation was provided, each patient going at least one evening each month to a concert, a play, or a motion picture, accompanied by the superintendent or some other suitable person. Patients were expected to attend services at their

own churches; this requirement was included in the posted rules, which, unlike the usual regulations, simply referred to the mother's responsibility for her child and to the home. Religious services or group prayers were never held in the home, but occasionally a brief reading or a selection from the Scriptures was substituted for the grace before meals.

Home XV

Originally intended for delinquent girls and women, this home was caring for three distinct groups at the time of the study: Unmarried mothers; problem girls, not necessarily sex offenders; and children. As the unmarried mothers were only a small proportion of the persons assisted, the policies in the main were formulated on the basis of service to the other two groups. The management was considering using the home as a reception place and clearing house for various types of girls 12 years of age and older.

The home was housed in a suitable building erected especially for its use, and it was in a good location. Single sleeping rooms, large sunny windows, a sleeping porch, and a pleasant yard all added to its attractiveness.

Patients entering the home were kept in a special isolation suite until the results of the medical examinations were known. A physician, who came upon call, had been interested for years in this place and had given faithful service. At his laboratory chemical analyses were made and results of Wassermann tests and vaginal smears determined. After six months of pregnancy each patient went to the prenatal clinic at the hospital, and the clinic's recommendations were carefully carried out at the home. Delivery was made at a good hospital, and each patient was kept there as long as necessary. If she needed to return later for any cause relating to her confinement she might do so and take her baby with her. The hospital kept all records of prenatal and confinement care and also a record for each infant. At the home the babies were seen by the house physician and by a pediatrist who was on the consulting staff. The well-trained, understanding superintendent cooperated well with the physicians.

The nurse gave particular attention to the pregnant women. Each one's room was changed from the third floor to the second when she neared confinement, and the nurse then gave her individual care. After returning from the hospital the mothers slept on the second floor near the nursery.

The diet was rated as "possibly inadequate" for both pregnancy and lactation; but the household was large, and differentiation for various inmates was not easy to carry out.

Probably the poorest phase of the medical work was that too many types were dealt with, so that the superintendent could not know enough about each patient's care in pregnancy and lactation. She had had some very serious handicaps to overcome and was doing well. The board of managers formerly had not been in favor of any special prenatal care, permitting the "natural process" to be unguided.

The superintendent was well prepared for social-service work with unmarried mothers, as she had a certain educational background as well as experience. She appreciated modern procedure and was identified with the social work of the community. Though unable to make complete case investigations, she visited the homes of most of her charges and made efforts to fix paternal responsibility. Babies were occasionally accepted on surrender, but never until after the nursing period and usually only if the mother proved to be mentally or morally unfit to assume maternal responsibility.

Mothers had the care of babies, and did housework, cooking, and laundry work, though there was no definite training except for housework. The home did commercial laundry work, but mothers were seldom assigned to that work.

A departure from the stereotyped recreation found in many homes was the use of a circulating library. Recreation outside of the home was limited to an annual picnic.

Local social workers found the home cooperative and helpful.

Home XVI

This large institution was well appointed in almost every detail. Its building had been planned for its work. It had plenty of baths and toilets, including separate ones for patients in isolation.

The medical work had been wholly changed since the return of its physicians from clinics in foreign countries, and many excellent reforms had been instituted. Some of the best medical work in the State was now done here. The prenatal care was excellent. A fully equipped dental clinic contributed to the success of the program. The home received patients with venereal infections and had excellent facilities for their segregation.

From birth all children were under the care of a pediatrist. At the time of the investigation he was studying the prevention of congenital syphilis and of ophthalmia neonatorum. The problems of infant feeding were also receiving intelligent consideration. The diet was "probably adequate" for pregnancy and lactation, and the amount of milk used was "adequate" for lactation. However, the babies might not be breast fed very long, as separation of the mother and her child might occur early.

The outstanding feature in the social work was the motive of protection of the mother. Methods and policies appeared to be formulated primarily with this end in view, as will be noted in the ready acceptance of babies and the use of assumed names. Babies were accepted, on surrender, for a financial consideration. Training the mothers for future employment was not recognized as part of the responsibility of the home, probably because the average period of stay was very short. This was one of the few homes giving care, without question, to unmarried mothers in pregnancies other than the first. It was also one of the few accepting women with any communicable disease and providing treatment.

Some of the board members were interested in promoting social service with a view to developing modern policies of investigation, fixing paternal responsibility, and improving the work of placing out children. The fact that the home was a member of the community chest showed that it participated in community work and that it was taking advantage of opportunities for progress. Local agencies found the home cooperative and used it to a considerable extent.

Home XVII

A lovely old residence, surrounded by beautiful grounds, the building housing this home was ideal for maternity-home work, and the home should have served the community in a far larger measure than its administrative, social, and medical policies permitted. The home had good equipment—excellent sleeping quarters, toilets, baths (including showers), and a pool on the grounds for summer bathing. Garden and fruit cultivation and the raising of chickens were outstanding features of the home's efforts for the health of the inmates.

If a girl had been referred to the home through an agency in the city she usually brought a record of a physical examination and was supposed to have a clean bill of health as regards venereal disease. The home claimed to refuse patients with venereal disease, but such patients were admitted and were treated either at the cooperating hospital or at the home.

The prenatal care was haphazard. The hospital where patients went for examination and advice was at a distance, and they did not go regularly. Delivery took place at the same hospital; the obstetrician gave the patients skilled service. The patient returned to the home in about 12 days, and though no further bedside care was necessary she was not expected to do her usual work for several weeks. There was usually a trained nurse on the staff, who under the supervision of a pediatrist took good care of the babies and also taught the mothers how to care for them. Every mother in the home was required to nurse her baby, and the nursing was done under supervision. The diet was not so good as conditions warranted, being rated as "probably inadequate" for both pregnancy and lactation.

This was one of the few homes studied which admitted unmarried women for pregnancies other than the first. This breadth, however, was not typical of the general policies. Analysis of case records revealed serious defects in discipline and management. Though the home was conceived in zeal for the moral rehabilitation of girls and women, the methods of care seemed to reflect quite different motives. Many cases were noted in which disciplinary problems were created by lack of understanding on the part of the staff. Too much emphasis was placed on the ability of mothers to do the routine work of the house. Almost half the expectant mothers who entered during the year before the study left before delivery—an indication of poor work in adjusting newcomers, who were naturally in an abnormal frame of mind. Theoretically babies were to be kept with their mothers for three months and breast fed if possible; actually, although

only a comparatively small number of separations of mothers and babies occurred, there seemed to be no fixed policy relative to separating them and accepting the babies for placement. No training was given mothers except in the care of their babies. Assignments to household duties were regulated according to the needs of the institution and not according to the need of the girls for training.

Few of the local workers who had used the home spoke favorably of it. Under different management this home could have held a place of real leadership in its field of work.

Home XVIII

The pleasant, homelike house and surroundings of this place were conducive to composure and health; but it was somewhat behind the times in certain medical details and social work was lacking.

The staff was not highly trained, and the practical nurse took considerable responsibility, especially about feeding the babies under 1 year of age, which would seem to require supervision by a physician.

All the medical care was given within the home. The physician's orders were followed as to prenatal care. Delivery took place in a room not well equipped for the purpose, and there was no standardized technique. Postnatal care was good. Patients were placed in separate rooms with single beds during this period and were kept there until convalescence was well established. Segregation for patients with communicable disease was provided as to sleeping quarters but not as to baths and toilets.

The diet was rated as "possibly inadequate" for pregnancy and was not rated for lactation, as the majority of the mothers did not nurse their babies, and it was said at the home that they were unable to. This condition seemed to be partly the result of the mental attitude of the girls, as influenced by the home. A commendable point in the routine was that the patients might retire to their rooms when fatigued or indisposed without any formality.

A large refrigerator on the third floor was a good feature in connection with caring for the babies' milk. The nurse attended to all the details of the care of bottles and the preparation of food according to formulas.

The superintendent claimed that she did not accept patients with venereal disease, but these might have been admitted without detection, as no Wassermann test was made and no vaginal smear taken. It had occurred twice in recent years that the presence of syphilitic infection in the mother was disclosed only at the birth of the baby.

No records of any health work were available at the home.

The home was a haven to the girl in distress, a shelter affording to the unmarried mother care before and after delivery, but it gave no other social service. Such privacy as an institution of this type afforded, efforts to make patients comfortable, and genuinely kind treatment constituted the sum total of care given. The superintendent, a woman well past middle age, of the motherly-housekeeper type, seemed to have no conception of the possibilities in her work.

This home required patients to remain an arbitrary length of time after delivery. This was unlike the practice in most of the homes studied, for the rules were generally flexible in this respect. Even when cases were known to be under the care of social agencies the patients had to complete the required period of stay before transfer would be considered. The required period of stay had been reduced twice, and at the time of the study it was two months. Although the mothers were required to remain in the home a certain length of time, no training was given them in preparation for future employment. They gained some experience in domestic work, but this work was assigned them according to the needs of the home and not according to their need of training.

Policies in relation to separation of mothers and babies were indefinite. Theoretically the policy was to encourage maternal responsibility; actually any mother unwilling to keep her child was assisted in placing it in a foster home for legal adoption. It seemed that the superintendent of the home felt impelled to place babies when excellent homes were offered. Nothing was done to fix paternal responsibility. The home was seldom used by social agencies.

Home XIX

With a private hospital on the grounds, this home was well equipped for the physical care of maternity patients. There was every facility for good, modern practice as to examinations and for some treatments.

Each patient was detained in isolation until complete examinations were made and the results reported. If a patient was syphilitic she was allowed to enter the home but was treated at another institution, being taken there as often as the physician ordered. Supplementary treatment was carried out in the home. Patients with gonorrhea were treated at the home under the direction of a venereal-disease clinic. Segregation facilities could be improved when needed. Single rooms, adequate baths and toilet facilities, and a solarium were part of the equipment.

The prenatal care was good, and records of all examinations were kept. Each patient went to the hospital department some days before her confinement and remained there after confinement for weeks, or even months. The superintendent was a trained midwife, and the obstetrical nurse was taking a course in midwifery. When specialists were needed for either the mothers or the children the superintendent called outside consultants.

Some of the most modern practices of obstetrics and pediatrics were not observed, the medical staff being opposed to them. For example, the infants were breast fed at night till they were 9 months old, and no supplementary feeding was given them until they were 1 year old. The diets for both pregnancy and lactation were rated "possibly inadequate." Only a small amount of dairy products was used.

The spirit of the place was beautiful, and the combination of a well-equipped, modern hospital and a homelike place to live presented rare possibilities for good work. A very good feature was the supervision over the health of the mother and her child, which was maintained after they left the home. Any patient might return for medical care or advice at any time after discharge.

This was one of the few maternity homes in the State which was licensed. Both white and colored girls were admitted, separate bedrooms being provided. Emphasis was placed on permanent maternal responsibility by the attitude and influence of the home and by intensive follow-up. Confidential relations between the patients and the home were deemed of paramount importance. The home even would not make social investigations, and it refused to allow any person other than the members of the staff to see the records.

The social policies, though not modern in some respects, were to be commended on certain points: Aftercare of mothers, refusal to place out children (which is not the function of a maternity home), absence of financial considerations from the procedure relative to disposing of the baby and discharging the mother from the home. On the other hand, the practice of discharging practically all mothers with their babies seemed questionable; a certain proportion of the unmarried mothers treated here must have been unfit to assume such responsibility. It seemed, too, that the work done to fix paternal responsibility was inadequate.

Training for future employment, though not diversified, was thorough.

The impression made by the home was of efficient work, a sympathetic attitude, and an earnest desire for the moral reclamation of the girls. The atmosphere of the home as well as the attitude of girls who were interviewed confirmed these impressions. The home was much used by local workers because of the personality of the superintendent, the consideration shown the mother, the excellent spirit in the home, and the results accomplished.

Home XX

This hospital represented the expression of the effort of a group of colored people to develop racial responsibility for unmarried mothers. Admirably located, surrounded by several acres of land, it was an ideal place for maternity-home care. It was fully equipped for nearly every variety of service pertaining to prenatal, confinement, and postnatal care. It did not have a dental clinic, but arrangements were made for this service elsewhere. Consultants in other departments not maintained regularly at the hospital were also available.

One noteworthy feature was the stressing of the use of certain foods for expectant mothers, the mothers being taught not only the caloric value of the food but the nutritive as well. This was taken up from the points of view of health and economy. Good educational work was done in prenatal care. The hospital was dealing with the problems of the colored race very efficiently.

Although the great freedom given the patients was excellent in some respects the lack of supervision presented certain dangers.

The social-service department consisted of one worker, a nurse whose training and experience did not fit her for social service. It is significant that unmarried mothers requiring follow-up, aid in obtaining employment, or other assistance were referred to agencies equipped to render the service needed, except when the assistance needed had to do with relieving a mother of her baby. The worker would accept any baby after it was 2 weeks old for placement in a boarding home or free foster home without any effort to develop other resources. She did all the investigation and supervision of the foster homes. This work was not well done, and the worker's lack of social training and experience was probably responsible.

In the main the social policies of this institution had the confidence of local social agencies.

Home XXI

An unmodern building, located in one of the older residential sections, noisy and crowded, placed this home under certain handicaps. Most of the patients admitted were received from local social agencies. Both married and unmarried women were accepted, though intensive social work was limited to the unmarried. Applicants with venereal disease were transferred elsewhere for treatment.

All the examinations and health work, up to the time of confinement, were done in the home by a physician, who called daily. A well-trained staff, consisting of the superintendent and one trained nurse, carried out all public-health measures and gave complete cooperation to the attending physician. The trained nurse worked with the girls in the sewing room and gave advice on preparation for motherhood. Prenatal care had not been very good but was being improved at the time of the study. The diets both for pregnancy and lactation were rated as "probably inadequate," but this feature also was being improved. The mothers were under the care of the physician after delivery, and the feeding of the babies was directed by him. All records of medical attention were kept at the hospital.

One bedroom for waiting mothers was somewhat crowded, but the rooms for the mothers who had returned from the hospital with their babies were very well arranged. For colored mothers the home reserved one bedroom containing three beds, and one table in the dining room.

In the superintendent's talks to the patients she stressed the mother's responsibility for whatever physical advantage she could give her child and reminded her that this was especially his due because of his social handicaps. The policies and standards of the home, at the time it was studied, were going through a transitional period. Recent affiliation with a case-working agency had resulted in the appointment of a superintendent whose qualifications promised complete reorganization and standardization of the social work. The statistics and data gathered reflected, in the main, the work of the earlier régime. The social policies reflected an appreciation of modern methods. This was shown in the provisions for follow-up work, in the practice of individual case work, in the exercise of judgment in regard to maternal responsibility, and in the absence of financial considerations. These policies, however, had not always been satisfactorily carried out up to the time of the study, because the personnel, in the main, had been untrained and had lacked the fundamental qualifications for social work. Analysis of records revealed a large proportion of unmarried mothers whose stay was brief either because they were dissatisfied or because they gave dissatisfaction. Reports from local social agencies indicated notable improvement under the new administration.

Home XXII

Founded about 50 years ago as a shelter for unmarried mothers, to whom at that time little provision was open except almshouses, this home had not changed its main policies, except to admit also married women. This departure was said to have been made because only a few patients were making use of the home. But at the time of the study, even though both married and unmarried women were admitted (two-thirds of the patients the year before the study were married), the accommodations were little used. Only one-third of the beds were occupied by patients at the time the home was visited, and the total number of patients the year before was but four times the number of beds.

The medical equipment was that of a good hospital. Daily visits of physicians and the constant attention of trained nurses and midwives obviated the necessity for going out to clinics. A strict regimen of daily bathing, proper dressing, and plain food was followed.

Although expectant mothers were admitted at any time during pregnancy and were kept for a short time after the period of hospital care in order to allow time for formulation of plans, the home did no social service, referring patients in need of such assistance to agencies equipped to render the help needed. In the absence of a social-service department this seemed a wise policy.

The home was little used by local social agencies, as they believed that better hospital care was afforded in other places. The superintendent was very cooperative in the matter of any cases placed by the agencies. On the whole the small number of patients served raised the question whether there was any need for this home.

Home XXIII

One of the oldest of the institutions studied, this large home had its beginning as a foundling asylum. The motive of protection of the unmarried mother, which influenced its early history, was apparent throughout the latter development of its work, which included addition of a maternity home and a maternity hospital, and, later, extension of the hospital work into general service for mothers and children. The fact that the married women delivered during the year of the study outnumbered the unmarried was significant; no longer might any woman in this institution be assumed to be an unmarried mother. The institution had a large building with facilities for isolation and segregation, which were well adapted for use in detecting and treating venereal disease. There was an especially good laboratory with a pathologist in charge who, besides giving the usual tests, safeguarded the household by analyzing the milk.

The health work for the patients was all done in the home, and strict standards were maintained. A physician was available every day, and pediatrists were called in consultation. Confinement took place in the home, and the delivery room was well equipped for emergencies. A staff of three obstetricians were on rotating service. Records of all the health work were available.

The diet was not formally rated, but a large amount of dairy products was used—an indication that the dietary regimen was probably satisfactory. Breast feeding was required. It was supervised and no dissimulation was possible. A small honorarium was given each week to the mother whose baby had made the greatest gain. The babies were weighed and measured and careful records were kept.

Outstanding features of the home's social policies were the training of mothers with the aim of giving them some definite preparation for life and the employment of a "house mother" and of a social worker with some training. The superintendent's methods of dealing with the girls indicated an understanding of the psychology of the work.

The one really serious defect in the social policy was the presumable discrimination in favor of girls whose financial condition made it possible for them to escape assuming responsibility for the nurture and care of their babies by surrendering them upon payment of a fee. Though the patients in the home all appeared to be satisfied and unrepressed, the discrimination must have had a bad influence on certain girls, who had not money enough to take advantage of the opportunity to surrender their babies. Efforts of the superintendent to improve this condition and her success in correcting other defects in policy during the short period of her administration rendered the situation less discouraging than it otherwise would be.

Home XXIV

By reason of a policy that no woman in need of obstetrical care might be rejected, this institution was a general receiving place from near-by parts of the State for pregnant women with venereal disease. It was a modern hospital, equipped for prenatal, confinement, and postnatal care; it provided for dental service elsewhere.

It had a "waiting ward," and it had for years assisted unmarried mothers with plans for themselves and their babies. Some time before the study a considerable amount of child placing had been done directly from the hospital. But at the time of the study the work was under the direction of a recently provided social-service department, and analysis of social histories revealed remarkable improvement in procedure. The periods of care of patients before and after actual hospital care were being shortened by the use of family-home and other community resources, so that the institutions could give service to a greater number of patients.

The daily routine showed that attention was paid to the physical comfort of pregnant women; definite rest periods were provided, regardless of the work to which the patients might be assigned, an unusual feature in the maternity homes studied. Introduction of occupational therapy was under consideration.

The social-service department was rendering some services which seemed to be beyond its scope. Although it was the policy of the department to refer to other agencies all cases not yielding readily to adjustment, instances were noted of double activity—by this department and another agency. Such duplication must have led to confusion and must have militated against the efficiency of both agencies.

Physical conditions were admirable, with the exception of lack of recreational facilities for unmarried women whose stay was long. This condition was being remedied by the utilization of outside resources.

CASE STORIES

A frank attractive girl of 20 had made her home with relatives since her infancy, when her mother had died. Her ties with these relatives were not strong and when she found she was pregnant she sought advice outside the family, consulting a local social worker, who brought her to the maternity home. The father of her coming child had disappeared when she told him of her pregnancy. After several months he returned and married her and then went west to go into business. He sent her money several times at the home. Later, when his business plans had matured and the girl was able to travel, he again returned and brought her and the child back with him to the West. During the interval the maternity home afforded the mother and the baby shelter and care.

An intelligent young woman, a high-grade factory operator, was admitted to the home through the assistance of her family physician. An attorney obtained from parents of the baby's father a private settlement of $400, out of which he declined to take any fee.

Complying with a regulation of the home, the mother nursed her baby for three months. After that she returned to her parents' home and left the baby in the maternity home, paying his board. When the child was 1 year old he was taken by his mother's parents, ostensibly an adopted child.

In a home which requires each patient to remain for three months after delivery the child of a 17-year-old girl had been placed in a foster home at the age of 3 weeks and immediately adopted. While the mother and baby were in the hospital an applicant for a baby had been taken to see them by the superintendent of the home, and soon the adoption was agreed to. The putative father of the child had not been communicated with, and the mother thought that he had no knowledge of her pregnancy. The one concern of the girl's family had been for secrecy, and the management of the home had fully cooperated with them. The girl chafed at the restraint imposed by the required stay, but this the management insisted on to give them opportunity for their work of moral reclamation.

A pretty, refined girl of 20, whose financial assistance in her home was needed because her mother was a widow, had come from a small town in an adjoining State to conceal her pregnancy. When the pregnancy was so advanced as to compel the girl to seek a temporary shelter she registered in the obstetrical clinic of a hospital. She was frightened at the thought of entering any "home"; she had heard that "they were all dreadful places." She was persuaded by the hospital social worker to enter this home. The worker chose wisely, for the atmosphere here was such as to disarm suspicion and win the confidence of patients. The girl's expression of her appreciation of what the institution had done for her constituted a real tribute to the management.

Although relatives urged the girl to give up her baby, she steadfastly refused to do so. While in the hospital the chief resident physician had urged her to place the child with friends of his who wanted to adopt a baby.

The superintendent of the maternity home had developed relations with a local agency by which she was able to refer the patient to it, so that necessary guidance and assistance could be given to her.

In one home a timid, appealing little foreigner was met, who seemed helpless about managing her affairs. She was doing fairly heavy and responsible household work in the home. Her baby had been placed in a free foster home when it was 15 days old. Before the baby's birth a relative of the father had brought the mother $100 and a message that he had gone to his home in a foreign country, that she was to take good care of the baby, and that he would return in a year and marry her. Despite these facts, the superintendent of the home decided that the mother could not care for the baby. The mother was very emphatic in saying that she had not given up her baby and that she would see that it had good care.

As this home insisted on legal adoption of all placed-out children, the superintendent was asked about her plans for this baby. She replied that she would not allow legal adoption during the year and that she would permit the mother to visit the baby. The superintendent required three months' service from the mother to compensate for this placement—certainly a questionable action. There could be no indebtedness, for delivery had occurred in a hospital outside of the home and the mother had worked all through the prenatal period.

During the study of one maternity home a certain expectant mother was repeatedly met. She was 24 years old, was dependable and capable, and had filled a well-paid domestic position for several years. One day this patient produced the clothes which she was making for the coming baby. They were inexpensive but tastefully and well made. This led to mention of her plans for the baby. With real grief she said that she would have to give him up for adoption because his father was disabled—a veteran of the World War—and her own help was needed in her home. The possibility of some other plan was intimated to the superintendent, who was present; she announced in an arbitrary manner that adoption of the baby was the only solution. Yet this was in a large city where many resources are available for mothers of this type.

A girl living in a small town concealed her pregnancy until near the end of it. When it was discovered by her parents the young man responsible could not be found. The family physician promised to arrange for sending the expectant mother to a city some distance away. Premature birth of the baby at home created consternation in the household. On the advice of a worker in a near-by institution, the mother and baby were taken by train a distance of 20 miles, one week after the child's birth, to an institution where it was understood that both would be accepted for emergency care, that the mother would return to her home soon, and that the institution would accept permanent custody of the baby. On their arrival the mother, as might be expected, was in a state of collapse. First aid was immediately rendered, and she and the baby were sent to a hospital. Here they were seen the following week, the mother critically ill.

Several months later this patient was again met in a maternity home to which she and her baby had gone from the hospital. On account of her changed appearance, due to excellent care, the bureau agent did not recognize her until she recalled the earlier meeting in the hospital. The weeks of nursing and care of the baby had changed the attitude of the girl's family and they were now awaiting developments instead of continuing with hasty and ill-considered plans for the disposal of the baby.

Appendix A.—CHILD-WELFARE STANDARDS APPLICABLE TO MATERNITY HOMES

Standards especially for maternity homes have not been formulated, but such portions of the Minimum Standards for Child Welfare formulated by the Children's Bureau Conference on Child Welfare Standards in 1919 as would apply to mothers and babies in these institutions may be stated as follows: [1]

MEDICAL STANDARDS

1. Complete physical examination by physician as early in pregnancy as possible, including pelvic measurements, examination of heart, lungs, abdomen and urine, and the taking of blood pressure; internal examination before seventh month in primipara; examination of urine every four weeks during early months, at least every two weeks after sixth month, and more frequently if indicated; Wassermann test whenever possible, especially when indicated by symptons.
2. Instruction in hygiene of maternity and supervision throughout pregnancy through at least monthly visits to a maternity center [clinic or physician] until end of sixth month, and every two weeks thereafter.
3. Instruction of expectant mothers in hygiene of pregnancy and early infancy.
4. Confinement by a physician or a properly trained and qualified attendant.
5. Nursing service at the time of confinement and during the lying-in period, or hospital care.
6. Daily visits by physician or nurse for five days, and at least two visits during second week.
7. At least 10 days' rest in bed after a normal delivery.
8. Examination by physician six weeks after delivery.
9. Cooperation with clinics, such as dental clinics and venereal clinics, for needed treatment during pregnancy.
10. Registration of all births.
11. Prevention of infantile blindness by treatment of eyes of every infant at birth.
12. Instruction under medical supervision to mothers in breast feeding and in care and feeding of children. This instruction should include:
    (*a*) Value of breast feeding.
    (*b*) Technique of breast feeding.
    (*c*) Technique of bath, sleep, clothing, ventilation, and general care of the baby, with demonstrations.
    (*d*) Preparation and technique of artificial feeding.
    (*e*) Dietary essentials and selection of food for infants and for older children.
    (*f*) Prevention of disease in children.
13. Hospital care, or provision for medical and nursing care at the home, sufficient to care for all sick infants and young children.
14. State licensing and supervision of all maternity homes.
15. General educational work in prevention of communicable disease and in hygiene and feeding of infants and young children.

SOCIAL STANDARDS

The child born out of wedlock constitutes a very serious problem, and for this reason special safeguards should be provided.

The treatment of the unmarried mother and her child should include the best medical supervision, and should be so directed as to afford the widest opportunity for wholesome, normal life.

---

[1] These are intended only as minimum standards and are not intended to limit in any way the degree of protection that a progressive State might desire to give its children. See Minimum Standards for Child Welfare Adopted by the Washington and Regional Conferences on Child Welfare, 1919 (U. S. Children's Bureau Publication No. 62, Washington, 1920).

Care of the child by his mother is highly desirable, particularly during the nursing months.

No parent of a child born out of wedlock should be permitted to surrender the child outside his own family, save with the consent of a properly designated State department or a court of proper jurisdiction.

Each State should make suitable provision of a humane character for establishing paternity and guaranteeing to children born out of wedlock the rights naturally belonging to children born in wedlock. The fathers of such children should be under the same financial responsibilities and the same legal liabilities toward their children as other fathers. The administration of the court with reference to such cases should be so regulated as not only to protect the legal rights of the mother and child, but also to avoid unnecessary publicity and humiliation.

Save for unusual reasons both parents should be held responsible for the child during his minority, and especially should the responsibility of the father be emphasized.

Appendix B.—CERTAIN STATE LAWS AND REGULATIONS AFFECTING MATERNITY HOMES

MINNESOTA

[Session Laws, extra session 1919, ch. 50]

An Act Defining and regulating maternity hospitals

Be it enacted by the Legislature of the State of Minnesota: SECTION 1. *Maternity hospital defined.*—Any person who receives for care and treatment during pregnancy or during delivery or within ten days after delivery, more than one woman within a period of six months, except women related to him or her by blood or marriage, shall be deemed to maintain a maternity hospital. The word "person" where used in this act shall include individuals, partnerships, voluntary associations and corporations; *Provided, however,* That this act shall not be construed to relate to any institution under the management of the State board of control or its officers or agents.

SEC. 2. *Licensed by board of control.*—The State board of control is hereby empowered to grant a license for one year for the conduct of any maternity hospital that is for the public good and that is conducted by a reputable and responsible person; and it shall be the duty of the board of control to prescribe such general regulations and rules for the conduct of all such hospitals as shall be necessary to effect the purposes of this act and all other laws of the State relating to children as far as the same are applicable and to safeguard the well-being of all infants born therein, and the health, morality and best interest of the parties who are inmates thereof. No maternity hospital shall receive a woman for care therein without first obtaining a license to conduct such hospital from said board of control. No such license shall be issued unless the premises are in fit sanitary condition. The license shall state the name of the licensee, designate the premises in which the business may be carried on, and the number of women that may be properly treated or cared for therein at any one time. Such license shall be kept posted in a conspicuous place on the licensed premises. No greater number of women shall be kept at any one time on the premises for which the license is issued than is authorized by the license and no woman shall be kept in a building or place not designated in the license. A record of the license so issued shall be kept by the board of control, which shall forthwith give notice to the State board of health and to the local board of health of the city, village, or town in which the licensee resides of the granting of such license and the conditions thereof. The license shall be valid for one year from the date of the issuance thereof. The State board of control may, after due notice and hearing revoke the license in case the person to whom the same is issued violates any of the provisions of this chapter, or when, in the opinion of said board, such maternity hospital is maintained without due regard to sanitation and hygiene, or to health, comfort or well-being of the inmates or infants born to such inmates or in case of violation of any law of the State in a manner disclosing moral turpitude or unfitness to maintain such hospital or that any such hospital is conducted by a person of ill repute or bad moral character.

Written charges against the licensee shall be served upon him at least three days before hearing shall be had thereon and a written copy of the findings and decision of the board upon hearing shall be served upon the licensee in the manner prescribed for the service of summons in civil actions.

Any licensee feeling himself aggrieved by any decision of the board may appeal to the district court by filing with the clerk thereof in the county where his hospital is situated within ten days after written notice of such decision, a written notice of appeal specifying the grounds upon which the appeal was made.

The appeal may be brought on for hearing in a summary manner by an order to show cause why the decision of the board should not be confirmed, amended, or set aside. The written notices and decisions shall be treated as the pleadings in the case and may be amended in the discretion of the court. The issues shall be tried anew by the court and findings shall be made upon the issues tried.

Either party may appeal to the supreme court from the determination of the district court within five days after notice of filing the decision, in the manner provided for appeals in civil action.

No revocation of license shall become effective until any appeal made shall have been determined. In case of revocation of a license, the board shall make a notation thereof upon its records and give written notice of such revocation to the licensee, or leaving a copy thereof with a person of suitable age and discretion living upon the premises. In case of revocation the board of control shall also notify the State board of health and the local board of health of the city, village, or town in which the hospital is situated.

SEC. 3. *Disposition of children.*—No person, as an inducement to a woman to go to any maternity hospital during confinement, shall in any way offer to dispose of any child or advertise that he will give children for adoption or hold himself out as being able to dispose of children in any manner.

SEC. 4. *Board of control to prescribe forms.*—The State board of control may prescribe forms for the registration and record of persons cared for in any such hospital, and the licensee shall be entitled to receive gratuitously from the board of control a book of forms for such registration and record. Each book shall contain a printed copy of this chapter. The licensee of a maternity hospital shall keep a record in the form to be prescribed by said board, wherein shall be entered the true name of every patient, together with all her places of residence during the year preceding admission to said hospital, the name and address of the physician or midwife who attended at each birth taking place at such hospital, or who attended any sick infant therein, and the name and address of the mother of such child; the name and age of each child who is given out, adopted, or taken away to or by any person, together with the name and residence of the person so adopting or taking away such child, and such other information as will be within the knowledge of the licensee and as the board shall prescribe.

SEC. 5. *Physician or midwife to make report.*—Every birth occurring in a maternity hospital shall be attended by a legally qualified physician or midwife. The licensee owning or conducting such hospital shall within twenty-four hours after a birth occurs therein, make a written report thereof to the State board of control giving the name of the mother, the sex of the child, and such additional information as shall be within the knowledge of the licensee and as may be required by the board. The licensee owning or conducting any such hospital shall immediately after the death in a maternity hospital of a woman, or an infant born therein or brought thereto, cause notice thereof to be given to the local board of health of the city, village, or town in which such hospital is located.

SEC. 6. *Inspection of hospitals.*—The officers and authorized agents of the State board of control, and of the State board of health and the local board of health of the city, village, or town in which a licensed maternity hospital is located, may inspect such hospital at any time and examine every part thereof. The officers and agents of the State board of control may call for and examine the records which are required to be kept by the provisions of this act and inquire into all matters concerning such hospital and patients and infants therein; and the said officers and authorized agents of the State board of control shall visit and inspect such hospitals at least once every six months and shall preserve reports of the conditions found therein. The licensee shall give all reasonable information to such inspectors and afford them every reasonable facility for viewing the premises and seeing the patients therein.

SEC. 7. *Information as to legitimacy of child.*—Whenever a woman, who within ten days after delivery of a child, or a woman who is pregnant, is received for care in a maternity hospital, the licensee of such maternity hospital or the officer in charge of such other hospital, shall use due diligence to ascertain whether such child is legitimate and if there is reason to believe that such child is illegitimate, or will be when born illegitimate, such licensee shall report to the State board of control forthwith the presence of such woman together with such other information as shall be within the knowledge of the licensee and as the board may require.

SEC. 8. *Disclosure of contents.*—No officer or authorized agent of the State board of control, State board of health, or the local boards of health of the city, village, or town where such licensed hospital is located, or the licensee of such a hospital, or any of its agents, or any person, shall directly or indirectly disclose the contents of the records herein provided for, or the particulars entered therein, or facts learned about such hospital, or the inmates thereof, except upon inquiry before a court of law, at a coroner's inquest or before some other tribunal, or for the information of the State board of control, State board of

health or the local board of health of the village, city, or town in which said hospital is located: *Provided, however*, That nothing herein shall prohibit the board of control, with the consent of any patient in such hospital, disclosing such facts to such proper persons as may be in the interest of such patient or the infant born to her.

SEC. 9. *Burden of proof.*—In a prosecution under the provisions of this act or any penal law relating thereto a defendant who relies for defense upon the relationship of any woman or infant to himself shall have the burden of proof.

SEC. 10. *Violation a gross misdemeanor.*—Every person who violates any of the provisions of this act shall upon conviction of the first offense be guilty of a misdemeanor. The second or subsequent offense shall be a gross misdemeanor.

SEC. 11. This act shall take effect and be in force from and after its passage.

SEC. 12. All acts and parts of acts inconsistent herewith are hereby repealed.

Approved September 22, 1919.

An Act To amend sections 4651, 4652, 4656, 4657, 4660, and 4661, General Statutes 1913, as amended by chapter 220, Session Laws 1917, and to repeal section 3 of chapter 220 of General Laws 1917, all of said sections relating to the record of births and deaths

* * * * * * *

SECTION 4. That section 4657 of the General Statutes of 1913 be, and the same is hereby, amended so as to read as follows:

* * * * * * *

"SEC. 4657. All superintendents, managers, or persons in charge of lying-in or other hospitals, almshouses, charitable or other institutions, public or private, to which persons resort for confinement, treatment of disease, care, or are committed by process of law, shall, at once, make and preserve a record of all the personal and statistical particulars relative to the inmates now in, or hereafter admitted to their institutions, that are required to be stated in the certificate of birth and death provided for by this act, and on or before the tenth of each month shall file with the State board of health, on a blank provided by such board for the purpose, a report of all births and deaths, or stillbirths, occurring in such institutions during the previous month. If admitted for medical treatment of disease the physician in charge shall specify, in the record, the nature of the disease and where it was contracted."

Approved April 14, 1921.

[Regulations of State board of health, edition of November 1, 1919]

* * * * * * *

REGULATION 13. All lying-in houses shall be licensed and the local health officer shall inspect those within his jurisdiction and satisfy himself that they are properly licensed or conducted.

REGULATION 14. No maternity hospital shall be granted a license unless same is constructed and maintained with such regard for sanitation and for protection of health of inmates as shall meet with approval of State board of health.

PENNSYLVANIA

[Laws of 1893, Act No. 19; Stat. 1920, secs. 14504–14506]

An Act To provide for the licensing and regulation of lying-in hospitals

SECTION 1. *Be it enacted etc.*, That it shall be lawful for the board of health of any locality to license any person or persons, other than an institution duly incorporated for such purpose, to establish and keep a lying-in hospital, ward, or other private place for the reception, care, and treatment of women in labor, upon written application filed with the said board, accompanied by the endorsement of six or more reputable persons, citizens of the county where such hospital may be situated, who shall certify to the respectability of the applicant and that the hospital, hospital ward, or other private place, shall only be used for legitimate, moral, and charitable purposes; and if, after due inquiry of such board of health, it is believed that the applicant is a proper person and the premises are suitable and properly arranged for such purpose, the said board of health shall grant a license for the purpose above mentioned upon the payment of a fee of five dollars. Such license shall continue in force for a period of two years, subject, however, to be revoked by the board of health granting the same upon the violation of the rules and regulations enacted by the said board of health

for the government of said hospitals, hospital wards, or other private places. The proprietor of every such hospital, hospital ward, or other private place kept for lying-in purposes shall keep a record in a book for that purpose, containing the full name and address of each person admitted, the date of admission, the date of birth of every child, the date of its removal, and the place to which such child shall be removed. Such hospital, hospital ward, or other private place shall be subject to the visitation or inspection at any time by the board of health granting the said license, or any special officer that may be appointed for that purpose by the court of common pleas, upon the petition of any society for the prevention of cruelty to children of the proper county.

SEC. 2. The proprietor of every hospital, hospital ward, or other private place for lying-in purposes to which a license has been granted according to section one of this act shall, within five days after the birth of any child, report to the said board of health the date and place of such birth, the name, sex, and color of the child.

SEC. 3. Whoever shall violate the provisions of section one of this act by keeping a hospital, hospital ward, or other private place for lying-in purposes for hire or reward, without license, shall be guilty of a misdemeanor, and for the first offense, upon conviction thereof, shall be punished by a fine not exceeding one hundred dollars, and for the second offense, upon conviction thereof, shall be punished by a fine not exceeding two hundred dollars and imprisonment of not more than one year, or either or both, at the discretion of the court.

SEC. 4. All acts or parts of acts inconsistent herewith are hereby repealed.

Approved the 26th day of April, A. D. 1893.

[Administrative Code, 1923]

An Act Providing for and reorganizing the conduct of the executive and administrative work of the Commonwealth by the executive department thereof and certain existing and certain new administrative departments, boards, commissions, and officers; abolishing, combining, changing the names of, reorganizing, or authorizing the reorganization of certain administrative departments, boards, commissions, bureaus, divisions, offices, and agencies; defining the powers and duties of the governor and other executive and administrative officers, and of the several administrative departments, boards, and commissions; fixing the salaries of the governor, lieutenant governor, and certain executive and administrative officers; providing for the appointment of certain administrative officers and of all deputies and other assistants and employees in certain departments, boards, and commissions; and prescribing the manner in which the number and compensation of the deputies and all other assistants and employees of certain departments, boards, and commissions shall be determined.

* * * * * * *

ART. XX.—POWERS AND DUTIES OF THE DEPARTMENT OF WELFARE AND ITS DEPARTMENTAL ADMINISTRATIVE AND ADVISORY BOARDS AND COMMISSIONS

SECTION 2001. *Powers and duties in general.*—The department of welfare shall, subject to any inconsistent provisions in this act contained, continue to exercise the powers and perform the duties by law vested in and imposed upon the department of public welfare and the commissioner of public welfare. It shall also exercise such additional powers and perform such additional duties as are imposed upon it by this act.

SEC. 2002. *Definitions.*—* * * (*d*) "Maternity home and hospital" shall mean any house, home, or place in which, within a period of six months, any person receives for care or treatment, during pregnancy or during or immediately after parturition, more than one woman, except women related to such person by blood or marriage within the second degree;

SEC. 2003. *Supervisory powers.*—* * * (*d*) All maternity homes and hospitals within this Commonwealth.

○

BOSTON PUBLIC LIBRARY
3 9999 05708 4913

SEP 1 4 1927